PATIENT DATA SHEET

Patient Name _____
Patient Birthdate _____
Your SSN _____
Your Employer _____
Your Occupation _____
Your Work Phone _____

Spouse/Significant Other Name _____
Spouse Birthdate _____
Spouse SSN _____
Spouse Employer _____
Spouse Occupation _____
Spouse Work Phone _____

Street Address _____ Rt._____ Box_____
City_____ State_____ Zip_____ Your Driver's Lic. # _____
Home Phone_____ Cell Phone_____

Name, Address, Phone # of relative/friend not living with you

Their Name _____ Home Phone # _____ Work Phone #_____
Address_____ City_____ State_____ Zip_____
Your Doctor's Name_____ Your Referring Physician _____
I am _____ I am not_____ allergic to any medications. If any please list. _____
_____

Please present your current insurance card at checkin. Your insurance contract is an agreement between you and your insurance company. As a service to you, we will file with your insurance carrier. You are responsible for payment of deductibles, copayments, and any non-covered service, at the time of service.

Primary Insurance Co._____ Phone #_____
Insurance Claims Address _____
Subscriber's Name _____ ID#_____ Group #_____
Subscriber's DOB _____ SS#_____ Place of Employment_____
Secondary Insurance Co._____ Phone # _____
Insurance Claims Address _____
Subscriber's Name _____ ID#_____ Group #_____
Subscriber's DOB_____ SS#_____ Place of Employment _____

I have been advised of and understand the financial policy of the practice.
****Because of the high cost of billing, we ask that you be prepared to pay for your visit before leaving our office.****
******PLEASE CHECK YOUR METHOD OF PAYMENT FOR TODAY'S VISIT******
Cash_____ Check Number_____ Debit Card_____ Mastercard_____ Visa_____
Discover_____ American Express_____

Authorization to release information / to pay benefits to Women's Wellness Center, P.A. I hereby assign payment directly to the designated provider for any medical/surgical procedures performed. I agree to be responsible for payment of services determined by my insurance carrier as not medically necessary or noncovered service. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

_____ _____
Patient Signature **Today's Date**
If patient is a minor, Parent/Guardian Signature)

FINANCIAL POLICY

Thank you for choosing Women's Wellness Center as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT: Cash, Personal Checks, Debit Cards, Master Card, Visa, Discover, American Express. and Money Orders.

Regarding Insurance **-** We may accept assignment of insurance benefits. However, we do request deductibles, co-insurance, and co-pays to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your current insurance information. Your insurance policy is a contract between you and your insurance company. We are not a part to that contract. In the event we do not accept assignment of benefits for your insurance company, we will require a pre-approved payment plan or a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account within 30 days, you will be requested to call them to have your claims processed. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Usual and Customary Rates **-** Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You may be responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates.

Minor Patients **-** Minors (for purposes of this paragraph, minors are those persons under the age of 18) will not be seen unless (a) accompanied by a parent or guardian, (b) we have a pre-authorized payment agreement, (c) under certain specific medical treatment plans required by law. The parents (or guardians of the minor) are responsible for the payment of services provided.

Missed Appointments **-** Unless cancelled prior to your appointment, our policy is to charge for missed appointments at the rate of a normal office visit. If three or more appointments are missed, you may be required to obtain medical care from another provider. Please help us serve you by keeping scheduled appointments.

Check Policy **-** A $27.00 return Check Fee will be assessed to your account for every check returned to the Women's Wellness Center, P.A. for insufficient funds. Patients who issue two (2) checks that are returned for "non-sufficient funds" will be required to make all payments by cash, money order, credit card, or debit card.

Collections Policy **-** We reserve the right to turn any patient over to a collection agency if it is deemed that the account is in default of payment obligations or for noncompliance with this policy. Should your account be turned over to a collection agency, you will be responsible for any and all administrative fees. Patients who have previously been in collections will be required to pay old balances in full and for all future visits at the time of service. Patients who do not comply with this policy may be dismissed from the practice. Only emergency care will be provided for a 30-day grace period following dismissal from the practice.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

X _____ Date _____

Signature of Patient
(If Patient is a minor, Parent/Guardian Signature)

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by the Women's Wellness Center, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of the Women's Wellness Center, P.A. I understand that diagnosis or treatment of me by the health care providers of the Women's Wellness Center, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. The Women's Wellness Center, P.A. is not required to agree to the restrictions that I may request. However, if the Women's Wellness Center, P.A. agrees to the restriction that I request, the restriction is binding on the Women's Wellness Center, P.A., its physicians and staff.

I have the right to revoke this consent, in writing, at any time, except to the extent the Women's Wellness Center, P.A. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This "protected health information" relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I have been offered a copy of the Women's Wellness Center's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that may occur in my treatment, payment of my bills, or in the performance of health care operations of the Women's Wellness Center, P.A.

A copy of the Notice of Privacy Practices for the Women's Wellness Center, P.A. is located at the reception desk and in the reception area. This Notice of Privacy also describes my rights and the Women's Wellness Center's duties with respect to my protected health information.

The Women's Wellness Center, P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking at the time of my next appointment.

I do____ I do not____consent to have my physician's office call me for reminders for appointments.

I do____ I do not____consent to have my physician's office mail me for reminders for appointments.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

INSURANCE POLICY

All insurance recipients must present their current insurance card at the time of service. If you do not have your insurance card, you will be considered a self-pay patient.

If you have insurance that is primary with Medicaid or Medicare as secondary, you must provide this information at the time of service. If you fail to disclose your primary insurance, your claim will be denied.

Patients will be responsible for all charges incurred prior to the presentation of their insurance card. **We Do Not** file claims for services provided after the services have been rendered.

All services not covered by your insurance company will be due at the time of service. It is your responsibility to know the provisions of your policy.

Tricare recipients must bring their authorization if enrolled in Tricare Prime or will be required to pay deductible and point of service.

Medicaid for pregnant women will only cover visits related to their maternity care.

If you deliver a male child and wish to have him circumcised, you must provide us with a copy of his insurance coverage so we can file for the procedure. If we do not receive proof of coverage, you will be responsible for the circumcision fee. Medicaid does not cover this procedure.

Please notify this office as soon as possible of any changes in your insurance coverage or change of insurance carriers.

If your insurance company has not paid their portion of your claim within 30 days, we request that you contact them to avoid further delays in payment.

Picture identification utilized for ID purposes only.

I fully understand the Insurance Policy and agree to abide by these policies.

_____ _____

(Signature of Responsible Party) (Date)

APPOINTMENT POLICY

This office has a 24 hour cancellation policy. By signing this form you understand and agree to the following policy:

1. As a courtesy, our staff will attempt to confirm your scheduled appointment 48 hours prior to the appointment. It is your responsibility to provide this office with correct telephone numbers where we can reach you.
2. Unless cancelled prior to your appointment, our policy is to charge for missed appointments at the rate of $25.00 per missed appointment. If three or more appointments are missed, you may be required to obtain medical care from another provider.
3. You agree to telephone one day in advance if you are unable to keep your appointment.
4. If you arrive more than fifteen (15) minutes late for a scheduled appointment you may be asked to reschedule.

_____ _____

Patient or Guardian's signature Date

*** PLEASE NOTE: Patients under the age of eighteen (18) will only be seen when accompanied by a parent, legal guardian or another adult with a letter giving us permission for treatment of the minor from the parent/guardian.