

TODAY'S DATE: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

SS#: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_

**\*\*\*\*\*Please note payment is due at the time of service\*\*\*\*\***

INSURANCE INFORMATION:

Primary Insurance: \_\_\_\_\_ Policy# \_\_\_\_\_

Claims Address: \_\_\_\_\_ Phone# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

SS# of Insured: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Employers Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy# \_\_\_\_\_

Claims Address: \_\_\_\_\_ Phone# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

SS# of Insured: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Employers Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Nearest Friend or Relative not living with you: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Were you referred here? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes by whom? \_\_\_\_\_

**FINANCIAL AGREEMENT:**

**ALL FEES ARE THE FULL RESPONSIBILITY OF THE PATIENT.**

You have the right to receive a full explanation of your bill, whether payment is coming directly from you or from a third party (such as an insurance company). A-ALL WOMEN CARE and WOMAN TO WOMAN GYNECOLOGY has the right to prompt payment for services rendered. It is your responsibility to provide accurate and complete information regarding your address, your insurance company and any limitations or restrictions on your insurance policy.

Our billing department will bill your insurance company free of charge and we will do all we can to help collect legitimate claims. However, it is up to you to provide our office with full and correct insurance information, and any forms which may be required. It is also your responsibility to know who your primary care physician is. If you are a member of a paid provider organization plan, we will bill the insurance company for you. You will be required to pay a preset co-payment and/or deductible (as per your policy) at the time of your appointment.

We are not equipped to extend credit for copayment/deductible amount. Please be prepared to pay your copay prior to your visit with the doctor.

In the event that your insurance company is slow to pay or denies the claim for any reason, you are responsible for payment of the account. This office does not have the authority to collect your insurance claim or to negotiate settlement of a disputed claim. You are responsible for payment of your accounts within the limits of you credit policy. We expect payment in full on any account within four months. Your eventual reimbursement will be determined by your insurance company. If you have any questions we will of course, assist you. However, your insurance agent or employer's insurance representative is equipped to answer questions and handle problems specific to your individual or group policy. Special arrangements for payment- if necessary - should be

made in advance through our billing department. You will receive a statement each month until your account is paid in full. Our statements show when your insurance company makes a payment on your behalf so you may understand what your balance is. We expect prompt payment of any balance not paid by your insurance company. If you have made prior arrangements with our billing department for a payment plan please honor those arrangements and pay as agreed.

I understand a \$25.00 return fee will be applied to my account if any checks or credit card are declined for insufficient funds. I also understand that if my account has no activity for 2 months, I will receive a 30 day notice before I am sent to collections.

I hereby authorize A-ALL WOMEN CARE and WOMAN TO WOMAN GYNECOLOGY to render medical care to myself or my dependent. I authorize them to release any information acquired in the course of my treatment as needed for my care, or when they are presented with written authorization to do so.

Signature of Patient or Parent if minor \_\_\_\_\_ Date \_\_\_\_\_

I \_\_\_\_\_ give clinical staff of A-All Women Care And Woman to Woman Gynecology, authorization to release and discuss any information about myself to the following people:

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

I understand that it is my full responsibility to notify the office of any changes.

Patient's Signature (or Parent's if minor): \_\_\_\_\_

## **NOTICE OF PRIVACY POLICY:**

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.**

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment. We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request,

except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer: We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of \_\_\_\_\_ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. Please contact us for more information, or you can contact the Health Department.

For more information about HIPAA or to file a complaint:  
The US Department of Health & Human Services Office of Civil Rights  
200 Independence Avenue, SW  
Washington, DC 20201  
Phone: 1-202-619-0257

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination. Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. The right to reasonable requests to receive confidential communications for protected health information from us by alternative means or at alternative locations. The right to inspect and copy your protected health information. The right to amend your protected health information. The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request.