CARE FOR WOMEN

Patient Information Form and HIPAA Privacy Compliance Patient Questionnaire

PLEASE FILL IN ALL BLANKS AND BRING TO YOUR APPOINTMENT
YOU MUST ALSO BRING YOUR INSURANCE CARD AND PICTURE ID:

Name: _____ **Date:** _____

(Please Print): *Last* *First* *MI*

Home Phone: ( ) _____

Address: _____ **Cell #:** _____

City _____ **State:** _____ **Zip** _____ **Work #:** _____

Employed: Yes ☐ No ☐ Student: Full time ☐ Part Time ☐ **E-Mail Address:** _____

Employer/School: _____ **Date of Birth:** _____

Employer Address: _____ **SS #** _____

City _____ **State:** _____ **Zip** _____ **Driver's License** _____

Occupation: _____ **Marital Status: M ☐ S☐ W☐ D☐ Sep☐**

Billing Address if Different: _____

Address City State Zip Phone #

PATIENT'S INSURANCE INFORMATION:

Is your insurance through your employer? **Yes ☐ No ☐** **Employer's Name** _____

Your Insurance Company Name _____ **Insured's Name** _____

Insured's Relationship To You: _____

Group/Policy # _____ **Insured's SS# and Date of Birth:** _____

AUTHORIZATION FOR *CARE FOR WOMEN* TO FILE YOUR INSURANCE

I authorize the release of any medical information necessary to process my insurance claim. I authorize and request payment of government or medical benefits to ***Care for Women*** *Patient Signature:* **X** _____ *Date:* _____

HOW DID YOU HEAR ABOUT US? ☐Friend ☐Relative ☐Dr. Referral ☐Yellow Pages ☐Welcome Wagon ☐Ad

Other: _____

HIPAA PRIVACY STATEMENT

All patients have the right to have confidential care provided. All information, medical or social, whether written, spoken, electronic, or computer generated, is to be held in strict confidence (please refer to the Care for Women Compliance Privacy Rules Notice).

If your lab testing is normal, our office may send you a private card notice. If anything is abnormal, our office will notify you by telephone. If you are not notified by phone or mail, please do not assume everything is normal. Call our office if it has been over two weeks since your test.

PATIENT RECORD OF DISCLOSURES

Yes ☐ No ☐ : May we speak to your emergency contact about medical information if you are unable to be reached in a timely manner?

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis.

EMERGENCY CONTACT (other than your Home # or Work #):

Name: _____ **Home Phone #:** _____

Work #: _____ **Other #:** _____ **Cell #:** _____

PLEASE NOTE: WE RESERVE THE RIGHT TO RELEASE MEDICAL INFORMATION IN EMERGENCY SITUATIONS

Your signature below only acknowledges that you have received the above HIPAA Privacy Notice regarding your rights to confidential care:

Signature of Patient or Guardian: X _____ **Date:** _____

( ) Signature declined. The practice made a good faith effort to obtain the patient's written acknowledgement of HIPAA Statement.

FOR STAFF USE ONLY: Date: _____ **Initials** _____

Year: _____

CARE FOR WOMEN

Patient Bill of Rights/Financial Responsibility

1) **I will make every effort to understand the benefits of my insurance plan, even to the extent of calling the benefits coordinator at my place of employment or my insurance carrier.**
2) **I will cooperate with this medical practice to assure prompt payment for all services I (we) receive, including non-covered services.**
3) **I agree to pay a $35 charge for any check that is returned by my bank for any reason.**
4) **If I receive maternity services, I agree to discuss any change of insurance plan with your business office before making the change. Failure may result in denial of payment, which makes the patient financially responsible.**
5) **I agree that this office can only bill for a diagnosis documented in my medical record. Thus, to Care for Women to change a diagnosis for the purpose of securing payment from my insurance carrier may result in an act of fraud.**

× _____ **INITIAL & DATE** ******I understand that Care for Women will only file Medicaid/Texas Health Network for services incurred once verification of coverage is obtained. Temporary ID cards or verbal authorization are not acceptable. Once coverage is verified, Care for Women will file only from that day forward, and for no dates prior to this verification. Any monies due Care for Women for services prior to the verification date are my responsibility***

Please sign below to indicate that you have read and understand the Bill of Rights/Financial Responsibility and HIPAA Privacy Statement.

× _____ **(signature)** _____ **(date)**

Any charges or fees quoted to you by employees or physicians of Care for Women are based on information given to us by your insurance company. The insurance company, emphasizes that it is not a guarantee and that the correct amount due by the patient can not be completely determined until after the claim is processed by them. Therefore, you may owe additional charges after we receive payment by the insurance company, for which you will receive a bill. We regret any inconvenience this may cause.

PATIENT CONSENT FORM
FOR MEDICAL AND/OR SURGICAL TREATMENT

I authorize the physicians at Care for Women to provide medical care including, without limitation, routine diagnostic procedures and medical treatment, which includes any procedures deemed necessary by the attending physician or other physicians or assistants, as may be designated by the physician, for medical care.

I understand that no warranty, guarantee, or assurance has been made by Care for Women with regard to the results of any treatments, examinations, or other medical care.

× _____ **(Signature of Patient)** _____ **(date)**

× _____ **(Witness' Signature)** _____ **(date)**

IF PATIENT IS A MINOR, PARENT OR LEGAL GUARDIAN MUST SIGN BELOW:

× _____ **(Signature of Patient)** _____ **(date)**

× _____ **(Witness' Signature)** _____ **(date)**

CONCERNING COMPLAINTS: Complaints about your physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants and acupuncturists, may be reported for investigation to the following address:

Texas State Board of Medical Examiners
P.O. Box 2018
Austin, TX 78768-2018
For assistance by phone, call: 800-248-4062