Patient Registration Form

Physicians For Women

Patient Information

Patient Information:

Last Name:	First Name: M.I.:	Previous Name (if applicable)

Mailing Address:

Apt #

City/ State/ Zip:

Home Phone:	Cell Phone:	Work Phone:

Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages:
(Please Select Only One Option) Voice Text

If Voice, Please Select Preferred Number:
Home Cell Work

Family Physician or Pediatrician:	Date of Birth:	

Marital Status: Divorced Married Single Other_____	Social Security #:

Employer Name:	Emergency Contact Name:

Emergency Contact Phone #:	Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If the patient is under the age of 18, the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:	First Name:

Date of Birth:	Social Security #:	Phone:

Address of Person Responsible:

City/ State/ Zip:	Relationship to Patient:

Additional PATIENT Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Email Address:

Race (please select):	Ethnicity (please select one):
White American Indian or Alaska Native Asian Hispanic Black or African American Native Hawaiian or Pacific Islander Other _____ Decline	Hispanic or Latino Not Hispanic or Latino Decline

Preferred Language (please select one): English Bosnian Indian (including Hindi & Tamil)
Sign Language Spanish Russian Other _____

Preferred Pharmacy Name & Location:

Drug Allergies:

By signing below, I certify that I have read, consent to and agree with Physicians for Women (PFW) Financial and Privacy policies. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to PFW all money to which I am entitled for medical expenses related to the services performed by PFW. I authorize PFW to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I choose to receive communications from PFW by text, phone call or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I authorize PFW to release medical/personal information, including electronically, to any treating facility, provider, laboratories, as well as others involved in my care. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment as well as provide pharmacies with pertinent medical/personal information needed as well. I understand I may choose to deny consent and request such forms to do so.

Medicare Beneficiaries: I request that payment of authorized Medicare benefits be made to PFW. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

(Initials)I have reviewed a copy of and agree to Physicians for Women Privacy Notice. _____

Signature of Patient \ Responsible Party: X _____ **Date:** _____

Printed Name of Patient \ Responsible Party: X _____ **Date:** _____

Physicians For Women

Patient Consent Form

I authorize Physicians For Women to discuss my personal health information (PHI) and/or financial information with family/friends as listed below. I understand that my personal health information may include information related to sexually transmitted infections, such as HIV/AIDs, as well as information regarding my behavioral or mental health or substance abuse. I understand this authorization is voluntary and may be revoked in writing at any time.

If you **DO NOT want any of your PHI or financial information to be discussed with anyone other than those required by law, then you may mark through the table below with **not applicable (N/A) and check the appropriate box below.**

Name	**Relationship to patient**	**Phone Number**
		( ) _____
		( ) _____
		( ) _____
○ **I DO NOT want my information shared with anyone other than myself.**		

I agree with the release of my PHI and /or Financial information as I have indicated above.

_____ Date _____
Signature of PATIENT

Consent for Patient Record Sharing
I authorize Physicians For Women to securely exchange medical/personal records and information electronically with other healthcare organizations where I am a patient, including pharmacies, all Baptist Health System and UAB locations. I understand that my records will only be exchanged with healthcare organizations where I have been treated.

_____ Date _____
Signature of PATIENT

Acknowledgement of Notice of Privacy Practices
I hereby acknowledge that I received a copy of the Notice of Privacy Practices from Physicians For Women, which sets forth the ways in which my personal health information may be used or disclosed by Physicians For Women, and outlines my rights with respect to such information.

_____ Date _____
Signature of PATIENT

*** **CONSENT OF MINORS**: In accordance with Alabama Law, Code of Alabama, Section 22 8-3 through 8-6, **patients 14 years and older,** or younger if pregnant, graduated high school, married or divorced, may seek treatment without consent from parents or legal guardians. Patients that meet this criteria **ALSO** must consent for Physicians For Women to release information to the **PARENT/LEGAL GUARDIAN**.
Any patient meeting this criteria MUST be the person to sign consents in regards to personal health information.

Physicians For Women's Financial Policy

INSURANCE

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, coinsurances and/or non-covered services which is due at the time of your visit.

2) It is your responsibility to keep us updated with your correct insurance information. **If the insurance information you provide is incorrect, you will be responsible for providing us with the correct insurance information within 30 days of notification or you will be responsible for those unpaid charges.**

3) It is your **responsibility** to **understand** your benefit plan with regard to, covered services and participating laboratories. For example**,**

- Not all plans cover annual preventative (well/routine) visits, radiology, and/or laboratory screenings. If these are not covered, you will be responsible for payment.
- Some plans have a limit as to the number of allowable well/routine visits/services/screenings per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment.

4) It is your **responsibility** to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

PAYMENT

1) If you do not have insurance or choose not to provide your insurance information, then you will be considered a self-pay patient. Self-pay patients are required to pay for services in **FULL** at the time of the visit.

2) If we do not participate in your insurance plan, payment in full is required from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.

3) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your account balance is due to be paid within 10 days of your receipt of your bill. A **$20 LATE FEE** will be added to any outstanding balances if not paid within 30 days of receipt of account statement.

4) For scheduled appointments, **PRIOR** balances **MUST BE PAID** prior to your next visit.

5) We accept cash, and most credit and debit cards.

FEES

1) A fee of $20.00 is due at the time of request for the completion of forms or letters, such as FMLA. This is a non-insurance covered service. Forms and letters will not be processed until the fee has been paid.

2) Non-physician or personal requests for copies of any medical records will be assessed administration fees according to the current state regulations. The fee is due at the time the records are delivered.

3) Any balance outstanding longer than 90 days will be forwarded to a collection agency, such as HOLLOWAY COLLECTIONS. You agree to accept the fees charged by any collection agency, which is 33.33% of the account balance and all costs and expenses including reasonable attorney's fees, we incur in such collection efforts. You also agree that Physicians For Women and any representing agents may contact you by telephone at any telephone number associated with your account, including autodialer and prerecorded voicemail numbers which could result in charges to you. We may also contact you by any other contact means you provided us with including emails and text messages.

4) A $30.00 fee will be charged for any checks returned for insufficient funds.

5) Our office may charge a fee for completing pre-authorization for any medication that is required.

6) We reserve the right to charge a NO SHOW Fee for any missed appointments. Please reschedule your appointment 24hrs prior to your scheduled appointment to avoid such possible charges.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name _____ DOB_____

Patient/Responsible Party's signature _____ Date_____

HIPAA NOTICE OF PRIVACY PRACTICES As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for medications, equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check on your current health status or in regards to your visit.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security and Workers Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our Manager in person or by phone at 334-290-4200.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.