☐ Winston Ashurst, M.D. ☐ Chip Garrard, M.D. ☐ Byron Lawhon, M.D. ☐ Al Newman, M.D. ☐ Jennifer Logan, M.D. ☐ Melissa Best, WHNP

Patient's Name_____ **Birth Date**_____ **Age**_____

☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOWED** ☐ **DIVORCED**

Address_____ **Email**_____

City_____ **State**_____ **Zip Code**_____

Home Phone_____ **SSN**_____

Employer_____ **Work Phone**_____

Occupation_____ **Cell Phone**_____

City_____ **State**_____ **Zip Code**_____

Parent/Spouse's Name_____ **SSN**_____ **Birth Date**_____

Relationship_____ **Home/Cell Phone**_____

Address_____ **City**_____ **State**_____ **Zip Code** _____

Employer_____ **Work Phone**_____

City_____ **State**_____ **Zip Code**_____

Drug Allergies_____

Who referred you to Physicians for Women? _____

Please Read and Initial Below:

_____ **CHAPERONES ARE AVAILABLE UPON REQUEST**

_____ ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. **IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN THEY ARE RENDERED.**

INSURANCE AUTHORIZATION AND ASSIGNMENT:

_____ I HEREBY AUTHORIZE PHYSICIANS FOR WOMEN TO FURNISH INFORMATION TO MY INSURANCE CARRIER CONCERNING ILLNESS AND TREATMENTS. I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS AND ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE PHYSICIAN FOR CHARGES NOT COVERED BY MY ASSIGNED INSURANCE CONTRACT.

PERSON RESPONSIBLE FOR PAYMENT SIGNATURE _____ **DATE** _____

PATIENT SIGNATURE _____ **DATE** _____

MEDICAL RECORDS RELEASE

Due to federal guidelines, we are now required to have a release form signed by the patient before we can give out any medical information to any person other than the patient.

Please list below the names, relationships and phone numbers of any authorized individuals (spouse, family members, friends, caregivers, etc) that we may discuss your medical or financial information with.

Name	Relationship	Phone Number
1.		
2.		
3.		

Please initial each item below to indicate your understanding

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ I understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

_____

Signature of Patient/Parent **Date**

OR

If you do not want any of your medical or financial information discussed with anyone other than yourself, please sign below.

_____

Signature of Patient/Parent **Date**

The above information is private and confidential and will be placed in your medical file. The information on this form will remain valid until we are notified otherwise.

May we leave medical information on your home answering machine?

Yes_____ or No_____

Effective Date: April 14, 2003

Notice of Privacy Practices

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.
If you have questions about this notice, please contact our office privacy officer at
334-290-4200

Our Obligations:
Law requires us to:

- Maintain the privacy of protected health information.
- Post this notice and make available for you a copy of our legal duties and privacy practices regarding your health information.
- Follow the terms of our notice that is currently in effect.

How we may use and disclose health information:
Described as follows are the ways we may use and disclose Health Information that identifies you. Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, or other personnel, including people outside our office who are involved in your medical care and need the information to provide you with medical care.

Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so they will pay for your treatment.

Health Care Operations: We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (your health plan) for their health care operation activities.

Appointment call, treatment alternatives and health-related benefits and services: We may use and disclose Health Information to contact you and to remind you of an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services which may be of interest to you.

Individuals involved in your care or payment for your care: When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as a family member. We may also notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort. We do not discuss appointment information. For example, we will not disclose times, dates or locations of your appointments to anyone unless we have written authorization from you.

Research: Under certain rare circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process.

Special Situations
As required by law. We will disclose Health Information when required to do so by international, federal, state or local law.

To avert a serious threat to health or safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health of the public or another person. Disclosures will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report birth defects and deaths, report child abuse or neglect; report reactions to medications or problems with products;

notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits & disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order for protecting the information.

Law Enforcement. We may release Health Information if asked by law enforcement officials if the information is: 1) in response to a court order subpoena, warrant, summons or similar process 2) limited information to identify or locate a suspect, fugitive, material witness or missing person; 3) about the victim of a crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be necessary: 1) for the institution to provide you with health care, 2) to protect your health and the safety or the health and safety of others, or 3) for the safety and security of the correctional institution.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you;

Right to inspect or copy. You have a right to inspect and copy, at your expense, Health Information that may be used to make decisions about your health care or payment for your care. This includes medical & billing records. To inspect and copy this Health Information, you must make your request in writing to the medical records clerk. All records will be copied within thirty days from the original request. Copying fees are applicable according to the laws of the State of Alabama and payable in cash. You may refer to our medical records request policy.

Right to Amend. If you feel the Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our office. To request an amendment, you must make your request in writing, to the medical records clerk.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations for which you have provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the medical records clerk.

Right to request restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care like a family member or friend. For example, you could ask we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the medical records clerk. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to request confidential communication. You have the right to request we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to the medical records clerk. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

If you have any questions regarding Physicians for Women's Notice of Privacy Practices, please contact the privacy offices at 334-290-4200.

PHYSICIANS FOR WOMEN

Winston M. Ashurst, M.D., F.A.C.O.G.
R.M. (Chip) Garrard, M.D., F.A.C.O.G.
Byron P. Lawhon, M.D., F.A.C.O.G.

W.A. Newman, III, M.D., F.A.C.O.G.
Jennifer J. Logan, M.D., F. A.C.O.G.
Melissa L. Best, WHNP-BC

PHYSICIANS FOR WOMEN
www.mypfw.com

No-show/late cancellation policy

We understand that you may need to cancel an appointment occasionally. In such circumstances, please contact us no later than 24 hours before your scheduled appointment time. You may do so by calling 334-290-4200 or 334-491-4200. Please leave a detailed message and we will call you back.

If you do not show up for your appointment, or cancel or reschedule within 24 hours of your appointment time, we will consider that a no-show. **No-show appointments may be subject to a $35 fee**. No-show fees are the patient's sole responsibility and must be paid in full before your next appointment. If the no-show fee might prevent you from receiving necessary care, please contact us.

We know that unexpected situations sometimes arise. In the case of emergencies or extenuating circumstances, we may waive the no-show fee. Waivers are determined on a case-by-case basis at the practice management's sole discretion.

If our office must cancel your appointment with less than 24 hours notice, you may choose to meet with a different provider (if available) on the same day, to reschedule, or to cancel. In these circumstances, we will not charge you a cancellation fee.

If you have questions about our cancellation policy, or you're experiencing an emergency, please call 334-290-4200 or email the practice manager at courtney@mypfw.com.

Patient signature:

Date:

287 Mitylene Park Drive
P.O. Box 240488
Montgomery, AL 36117
P 334-290-4200
F 334-290-4190

Prattville Medical Park
635 McQueen Smith Road, Ste E
Prattville, AL 36066
P 334-491-4200
F 334-491-4201

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Melissa L. Best, W.H.N.P.

Feb. 16, 2015

Effective immediately, a $20 late fee will be added to any late copay or any balance that ages over 30 days.

I understand that I will be responsible for fees, copays and balances incurred at Physicians for Women. I understand that payment arrangements must be made with the insurance department at Physicians for Women if my account cannot be cleared within 30 days.

Sign

Date

Privacy Practice Ackowledgement

I have obtained a written notice of the privacy practices of the Physician for Women. By signing below I acknowledge I have received and read the privacy practices. This acknowledgement will be retained in my medical file.

Patient's Signature

Date

Prattville Medical Center
635 McQueen Smith Road
Prattville, Alabama 36066
334-491-4200
Fax: 334-491-4201

287 Mitylene Park Drive
P.O. Box 240488
Montgomery, Alabama 36117
334-290-4200
Fax: 334-290-4190

Holloway Collection Fees

All delinquent accounts over $20 will be sent to Holloway Collections. Physicians for Women will make every attempt to contact the patient before turning the account over to Holloway Collections.

Please read and sign the following policy.

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

Consent To Contact Debtors On Their Cell Phones:

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:
You agree, in order for us to service your account or to collect monies you may owe, that Physicians for Women and/or our 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 sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Physicians for Women, employees and/or agents may contact me/us as described above.

_____ _____

Responsible Party Signature(s) Date

Approved 04/30/2015