

***The Women's Group***  
***Patient Information***

Last name: \_\_\_\_\_, First name: \_\_\_\_\_ MI \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status \_\_\_\_\_  
DL Number: \_\_\_\_\_ State: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**Pharmacy Information:**

**We can occasionally provide you with fast, convenient service if we electronically transmit requests to your pharmacy of choice. Indicate below your preference:**

Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

**Message Consent:**

The Women's Group is dedicated to providing you with fast and reliable information concerning your care. In many cases, we may not be able to talk to you directly because you may be away from your telephone. One convenient alternative is to leave a message for you to check later. Email is a particularly helpful means of communication, as we can often send you a related publication or other source of information. However, these messages may contain confidential issues despite their importance to your care. Please indicate your wishes below by simply initialing one or more of the following choices. If you do not have any of the devices below, simply leave them blank.

I authorize the staff of The Women's Group to leave or transmit important and potentially confidential information to one of more of the following:

\_\_\_\_\_ An answering machine at home or cell phone number listed above.

\_\_\_\_\_ Voice mail at work number listed above, only if voice mail message specifically mentions your name.

\_\_\_\_\_ Email address listed in the space above.

Do you check your messages regularly? Yes \_\_\_\_\_ No \_\_\_\_\_

**Insurance information:**

Name of Primary Insurance: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Relationship to Subscriber: \_\_\_\_\_

Name of Secondary Insurance: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Relationship to Subscriber: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT**

The notice contains information regarding potential uses and discloses of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 “HIPAA”) that may be made by the Practice, and of my rights and the Practice’s legal duties with respect to my protected information. A copy of the Notice of Privacy Practices is provided in our waiting areas for my convenience. I have had the opportunity to review the Notice and take a copy with me if I so choose.

X Signature: \_\_\_\_\_ Print: \_\_\_\_\_ Date: \_\_\_\_\_

**FINANCIAL POLICIES**

**AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN**

Initial \_\_\_\_\_ I hereby authorize the office of The Women’s Group to release any medical information required during the course of examination and treatment to my insurance company(ies) and permit payment due for their services rendered directly to them. I recognize and accept responsibility for services rendered regardless of insurance coverage.

**PREVENTATIVE CARE**

Initial \_\_\_\_\_ Your health insurance plan may not provide coverage for preventative services. It is important that you contact your insurance provider to determine if your plan offers benefits for this service and what their scheduling guidelines are for it. We use industry standard codes and guidelines to submit claims to the insurance companies based on the scheduled encounters and documentation in the patient’s medical record. Current laws regarding fraud and abuse with billing procedures prohibit us from changing the procedure codes and/or diagnosis codes in order to get the claim paid by the insurance company.

**FINANCIAL POLICY**

Initial \_\_\_\_\_ Our office is committed to providing quality and cost-effective healthcare to our patients. In today’s insurance environment it is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorizations or referrals prior to your appointment with us. It is your responsibility to understand the limits and restrictions affecting coverage for services provided by our specialty. If your insurance company requires you to use a specific lab, it is your responsibility to notify us of that. Insurance reimbursement is a contract between you and your insurance company. As a courtesy to you we will file all primary and secondary claims for you. We will require a current copy of your insurance card(s) in order to do this and will need to be informed of any changes in insurance status. You will be responsible for all co-pays, deductibles, and co-insurance amounts, including amounts not covered by a secondary insurance policy along with the entire amount of non-covered services. We appreciate payment for services at the time they are rendered. For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover, and American Express. We also realize that healthcare is sometimes an unplanned event, so we will attempt to accommodate your personal needs as circumstances require. In order to best meet your needs please call our business office at (850)494-6212 with any questions you may have regarding our financial policy and procedures. Patients who do not have insurance coverage (or proof of coverage) or who chose to receive non-covered services are expected to pay in full at the time of service. If you cannot pay the full amount then you must make satisfactory payment arrangements with our business office prior to receiving services.

**I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights and responsibilities.**

X Signature: \_\_\_\_\_ Print: \_\_\_\_\_ Date: \_\_\_\_\_