WomanCare Inc.

Contemporary Obstetrics and Gynecology

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Please print these pages, complete, and bring to your appointment.

We would like to thank you for choosing **Womancare, Inc.** as your OB/GYN provider. Our physicians and staff are committed to providing you with excellent care. Our goal is to make your visit as pleasant and as comfortable as possible. You are important to us and we look forward to developing a positive and **Enclosed you will find a Patient Registration form, Financial Policy/Notice of Privacy Practices and Acknowledgement and Consent for treatment form**. Please take the time to complete these forms and bring them with you to your appointment. Completing these forms in advance will save time during the registration process and allow us to be more focused on answering your questions and completing the clinical examination.

In addition, please bring the following items with you:

- **Your Insurance card(s)**
- **A Photo ID**
- **A referral (if required by your insurance plan)**
- **Your copayment (if required by your insurance plan)**
- **A list of any medications you are currently taking**

As part of your healthcare it is the patients responsibility to keep your scheduled appointment, call to cancel within 24 Hours, reschedule, and have your lab work done. Our phone number is **304-366-6100.** Please plan on arriving **15 minutes early to your scheduled appointment.**

Our office will **collect all co-pays, co-insurance and deductibles at the time of your visit.**

Again, thank you for choosing **Womancare, Inc**. and on behalf of our entire staff, we look forward to meeting you and providing you with quality care.

Sincerely,

Doctors & Staff

General Consent for Treatment

I hereby authorize the providers of WomanCare, Inc. to perform and do hereby consent to such medical treatment as he/she feels is necessary, including diagnostic procedures, medical examinations, and treatment as may, in his/her opinion, be medically necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of any procedures, treatment, or examination.

_____

Patient or Representative (printed)

_____ _____

Patient or Patients Representative (signature) Date

_____ _____

Witness for all statements Date

Electronic Device Policy

To provide security and privacy to our patients and employees, WomanCare, Inc. prohibits the use of electronic devices in our office. At no time should a photo or recording of a patient or employee be taken without written consent. By signing below, I agree that I have been advised and knowledge this policy and will adhere to this agreement.

_____

Patient or Representative (printed)

_____ _____

Patient or Patients Representative (signature) Date

WomanCare, Inc.

PATIENT FINANCIAL POLICY

WomanCare, Inc believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a form of identification due to many cases of identity theft.

2. INSURANCE: We are participating providers with most insurance plans. We will file all insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from the insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejected for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

3. RETURNED CHECKS will incur a $30 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the$30 service fee and collections action. All bad checks written to this office are subject to collections.

4. ACCOUNTING PRINCIPALS: Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

5. FORM FEES: completing insurance forms, copying medical records, etc… Requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence. Copying fees for Medical Records is $10 and additional $0.50 per page. WomanCare, Inc. will have 15 business days in which to copy records before making them available for patient pick up, payment is required before the records will be released and after patient has signed a form authorizing records' release.

6. RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to **WOMANCARE, INC.** for charges not covered by the assignment of insurance benefits.

7. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer, and set over directly to **WOMANCARE, INC.** sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize WomanCare, Inc. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to WomanCare, Inc. I authorize WomanCare, Inc. to release all medical information (including, but not limited to, information

on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

8. INSURANCES WE WON'T BILL: We do not bill out-of-state Medicaid plans. The patient will be responsible for the services in full.

9. RELEASE OF INFORMATION: I hereby authorize and direct **WomanCare, Inc.** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

10. MINOR PATIENTS: The parent/guardian of a minor is responsible for payment of the minor's account balance. A minor who is not accompanied by a parent/guardian will be denied any non-emergency treatment unless charges for the treatment have been pre-authorized. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents. Any court-ordered responsibility judgement must be determined between the individuals involved, without the inclusion of WomanCare, Inc.

11. DIVORCED PARENTS of PATIENT: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate which each other about the treatment and payment issues.

12. INSUFFICENT INFORMATION: I understand if I do not provide sufficient demographic and billing information to WomanCare, Inc., which results in a bad address, etc… and I am unable to be contacted through verbal or written communication, my account may be sent to a collection agency and result in possible discharge from the practice. I understand that I may not be able to schedule an appointment until this has been paid in full.

13. STATEMENT PROCESS: Payment is due upon receipt of statement of first statement. If not paid you will receive a Past Due and then Final Notice. If the balance has not been paid within this time frame, the account may be sent to collections with additional fees added to account (see below).

14. COLLECTION FEES: I understand that in the event my account is place in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees and collection agency fees. I understand that these additional fees will be my personal responsibility to pay in full.

15. NO-SHOW FEE: If you do not show for your appointment, we will assess you a $15.00 missed appointment fee.

BILLING OFFICE: If you have any questions in regard to any of your billing statements, our accounts receivable staff at WomanCare, Inc. is available to assist you. **CALL 304-366-6100.**

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient (or parent/guardian, if applicable) Date

_____ _____

Print name of parent/guardian (if applicable) Print patient name

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT AND CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this Acknowledgement. The Notice of Privacy Practices is also provided in the waiting area. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations;
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice;
- The Practice reserves the right to change the Notice of Privacy Policies;
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions;
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease; and
- The Practice may condition treatment upon execution of this Consent.

_____
Patient name (printed)

_____ _____
Patient signature Date

_____
Personal Representative Name (printed)

_____ _____
Personal Representative Signature Date

(This allows you to give WomanCare, Inc. permission (authorization) to disclose your Protected Health Information to a person that will act as your personal representative, such as your spouse. This authorization does not give your Personal Representative authority over any treatment or direct care decisions.)

- ☐ I may be contacted by phone AT HOME when necessary.
- ☐ I may be contacted by phone AT WORK when necessary.
- ☐ I may NOT be contacted by phone at any time.
- ☐ A message regarding my test results, scheduling, or return phone calls from my doctor may be left on my answering machine/voice mail or can be given to the person answering my home phone.

PATIENT APPROVED CONTACTS

PATIENT NAME: _____ Date of Birth: _____/_____/_____

☐ NOT DESIGNATING ANYONE AT THIS TIME: _____ _____/_____/_____
Initials Date

PLEASE NOTE: If any individual other than those listed below contact WomanCare, Inc. regarding the above name patient's personal health information, he or she will be referred back to the patient. In authorizing these individuals we will also assume that there are no limitations in communications regarding the patient.

CONTACT 1: (please print)

Name: _____

Relationship to patient: _____

Contact Number (_____) _____-_____ Emergency Response Person: YES / NO

CONTACT 2: (please print)

Name: _____

Relationship to patient: _____

Contact Number (_____) _____-_____ Emergency Response Person: YES / NO

CONTACT 3: (please print)

Name: _____

Relationship to patient: _____

Contact Number (_____) _____-_____ Emergency Response Person: YES / NO

Patient / Representative Signature:

_____ Date: _____/_____/_____

IF signed by Representative, describe authority to act on behalf of patient:

_____

_____

REGISTRATION FORM

Today's Date:	Pharmacy of Choice: _____ Pharmacy Location: _____

PATIENT INFORMATION

Patient's last name:	Patient's first name:	MI:	Former or Maiden name:

Address:	City:	State, Zip Code	Birth date:	Sex:
				M F

Social Security #	Home phone #	Cell phone #

Employer:	Employer phone #	Occupation:

Employment: ☐ Active ☐ Retired ☐ Unemployed ☐ Student ☐ Disabled

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Race:	Ethnicity:	Preferred Communication: **How would you like to be reminded of appointments (choose all that apply)**
☐ African American/Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Caucasian/White ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline	☐ Home phone ☐ Cell phone ☐ Work phone ☐ Text ☐ Email address: _____

INSURANCE INFORMATION

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Grandchild ☐ Other
If the patient is <u>not</u> the subscriber complete the information below:

Primary Insurance:		Subscriber name:	
Subscriber's SS#		Birth date:	
Policy / ID #		Group #	
Subscriber's Address: ☐ Same as patient's			

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Grandchild ☐ Other
If the patient is <u>not</u> the subscriber complete the information below:

Secondary Insurance:		Subscriber name:	
Subscriber's SS#		Birth date:	
Policy / ID #		Group #	
Subscriber's Address: ☐ Same as patient's			