Women's Health First

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PATIENT INFORMATION

Patient Name ______________________________________ Date of Birth _____________

Street Address____

City, State ____ Zip Code_____________

Home Phone ____________ Mobile Phone ___________

Email address ____

Occupation ____

Marital Status (circle) Single Married Widowed Divorced

Primary Insurance ____

Name of Card Holder (if not patient) _____________________________________

Date of Birth of Card Holder (if not patient) _________________

Relationship of Card Holder to patient (circle): Partner Spouse Parent

Card Holder's Address (if different than patient)

____

Preferred Pharmacy (name, address & phone number)___________________________________

____

Emergency Contact Information

__________________________ ___________________ ____________________
Name Phone Number Relationship

Signature_____________________________________ Date_______________

Updated:12-21-2021

Women's Health First

Assignment of Benefits:

I hereby assign all medical and or surgical benefits to which I am entitles including major medical, private insurance and any other health plans to Women's Health First. This agreement will remain in effect until evoked by me in writing. A photo copy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee all information necessary to secure payment.

Patient's Name___________________________

Date of Birth ____________

Signature of patient or guardian _____________________________

Date: _____________________

Women's Health First

Health Information Communication Preferences

To provide quality care there are times we may need to contact you regarding appointments, test results and follow-up care. Please indicate your preferences for contact (circle all that apply)

Home Phone Mobile Phone E-mail

Permission to leave clinical information on your voicemail. Yes No

Permission to send an email with reminder/clinical information. Yes No

Permission to send text message for appointments. Yes No

Authorization to Release Information

Many of our patients allow family members such as their spouse, significant other, parent or children to call and request the results of tests, procedures and financial information. Under the requirements of the Health Insurance Portability and Accountability Act and federal regulations, we are not allowed to give this information to anyone without the patient's consent. If you would like to have your medical information, any diagnostic test results and/or billing information released to any family members you must sign this form.

I understand that to revoke this permission, a written authorization must be provided to Women's Health First. __________ ***INITAL***

I authorize Women's Health First to release my records and any information requested to the following individuals.

1.______________________________ ____________________ ______________
Name Relationship to Patient Phone Number

Please circle which type of information can be released:

Clinical Information Results of Labs Billing Information

2.______________________________ ____________________ ______________
Name Relationship to Patient Phone Number

Please circle which type of information can be released:

Clinical Information Results of Labs Billing Information

Patient Name (please print) ___________________________

Date of Birth _______________

Patient signature __________________________________ Date_________________

Women’s Health First
Notice of Drs. Judith and Susan Forster’s Health Privacy Policy

The Health Insurance Portability and Accountability Act (HIPPA) of 1996 is a Federal Law which regulates how the privacy of your health information must be maintained and how the information may be used. This law provides you with certain rights and specifies penalties for the misuse of your health information.

HIPPA authorizes the release of private health information for purposes of treatment, payment and health care operations. For example, HIPPA allows a physician’s office to provide your lab tests and visit notes to another physician to aid in your treatment. Physician offices may submit information to your insurer in order to facilitate the processing of your insurance claims. And physician offices may disclose information to a health care facility to ensure proper care if you are admitted.

There are other unusual situations in which HIPPA allows a physician office to disclose health information. This includes a court order of competent jurisdiction to public health authorities when required by law or for the purposes of national security.

Any other uses or disclosures can be made only with your written consent. In such circumstances, you may limit the information released. You may withdraw your permission at any time, by submitting a written request to the office. Information released prior to your written request cannot be retracted or changed.

You also have the following rights:

- The right to expect that your private health information will not be released to anyone other than yourself or to the specific people you requested to be informed on our office Health Information Communication Preferences form.
- The right to inspect your medical record.
- The right to receive a copy of your medical record. We ask that you make this request in writing. There is a fee for this service.
- The right to receive an accounting of health information disclosures.

We reserve the right to change the terms of this policy and will post any revisions.

If you feel your privacy protections have been violated, you may file a written complaint with our office and/or the Office of Civil Rights (ORC), U.S. Department of Health & Human Services.

I acknowledge that I have received a copy of the Women’s Health First’s Privacy Policy.

Signature ____________________________

Date ________________