PRINT

Women's Health Associates

PATIENT INFORMATION

Patient: _____
(Last) (First) (MI)

Date of Birth _____ Gender: M F SSN: _____

DEMOGRAPHIC INFORMATION

Marital Status	Preferred Language	Race	Ethnicity
☐ Single	☐ Unspecified	☐ Unspecified ☐ Black or African American	☐ Unspecified
☐ Married	☐ English	☐ White ☐ Native American or other Pacific Islander	☐ Hispanic or Latino
☐ Separated	☐ Spanish	☐ American Indian/Alaska Native ☐ Other	☐ Not Hispanic/Latino
☐ Divorced	☐ Other: _____	☐ Asian	☐ Unknown
☐ Widow			

How did you hear about us? _____

Employer: _____ City/State: _____ Phone: _____

CONTACT INFORMATION

Address: _____
(Street) (City) (State) (ZIP)

Home: _____ Mobile: _____ Other: _____

Email: _____ Preferred Contact: Phone Text Letter Email

Emergency Contact and/or Guarantor: _____ Relation: _____

Home: _____ Mobile: _____ Other: _____

BILLING INFORMATION

Select: ☐ Self Pay ☐ Medicare/Medicaid ☐ Commercial Insurance ☐ Tricare/VA ☐ Employment Related

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I give permission for Women's Health Associates to provide any information about my medical condition, medical needs, medications, or the status of my account to the following individual(s). I understand that I must give expressed permission for Women's Health Associates to discuss any information related to mental health conditions and/or sexually transmitted diseases unless allowed by law.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

☐ *Patient declines releasing any information to a designated person*

CONFIDENTIAL COMMUNICATION REQUESTS

From time to time, it is necessary to contact you by telephone for test results or other information. Of our patients are not available when we attempt to contact therefore, we would like to leave detailed voice messages. In order to protect your privacy, we need your permission to leave detailed phone messages on your phone.
Please choose one of the following:

☐ ***I DO CONSENT*** *for Women's Health Associates to leave detailed messages on the following number: _____*

☐ ***I DO NOT CONSENT*** *to have detailed messages left on my phone.*

***THIS RELEASE WILL BE IN EFFECT UNTIL REVOKED OR UPDATED BY THE PATIENT. FOR MINORS, THEY WILL BE ASKED TO COMPLETE ONCE THEY TURN 18 YEARS OF AGE. ***

_____ _____
Signature of Patient or Legal Guardian **Date Signed**

PLEASE READ AND SIGN BELOW

Assignment of Benefits: *I hereby assign all applicable insurance benefits and direct that payment be made directly to Women's Health Associates, PLLC for all services provided during my visit.*

Release of Information: *I authorize Women's Health Associates, PLLC to furnish medical and other information necessary to process insurance claims on my behalf. This information may be released to my personal physician and, upon request, to any other healthcare provider who may need the information for continuity of care.*

Financial Responsibility: *I understand and agree that I am responsible for payment on all charges including those not paid by my insurance at the time of service. If I fail to make payment in full for services that are rendered to me within 90 days of the date of service, my outstanding balance will be sent to a collections agency. I understand that if my account is transferred to a collections agency, any discounts I may have received by WHA (excluding insurance contract) can be reversed.*

Appointments: *I understand that if I do not notify Women's Health Associates, PLLC of a cancellation of my appointment at least 24 hours prior to the scheduled appointment. On my second occurrence, I may be assessed a fee and/or dismissed from the practice for multiple occurrences.*

Treatment Authorization: *I am willfully requesting treatment and consent to services provided by, or at the direction of the attending provider at Women's Health Associates, PLLC. I understand and agree that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of the patient's care or treatment. I authorize a copy of this document to be used in lieu of the original.*

Liability: *I understand that Women's Health Associates, PLLC is only responsible for the acts of its employees acting within the scope and course of their duties. I understand that persons who are not employed by Women's Health Associates, PLLC may be involved in my care and treatment, including but not limited to other practitioners, laboratories, diagnostic test facilities, contractors, vendors, product technicians, etc. I understand that Women's Health Associates, PLLC is not liable for the acts or omissions of non-employees or employees acting outside the course and scope of their duties.*

Receipt of Privacy Practices: *I have been offered and/or provided with a copy of the Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state regulations. I acknowledge the receipt of Women's Health Associates Notice of Privacy Practices.*

_____ _____

Signature of Patient or Legal Guardian ***Date Signed***