

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MI _____

HOME PHONE _____ BIRTHDATE _____

MARITAL STATUS: S _____ M _____ D _____ SEP _____ W _____

ADDRESS _____ APT #/LOT # _____

CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY # _____ - _____ - _____ DRIVER'S LICENSE # _____

HUSBAND'S OR PARENT'S FULL NAME _____

PRIMARY INSURANCE

COMPANY _____ POLICY HOLDER _____
POLICY # _____ GROUP # _____

SECONDARY INSURANCE

COMPANY _____ POLICY HOLDER _____
POLICY # _____ GROUP # _____

IS THE PATIENT ON MEDICAID? _____ MEDICARE? _____

PATIENT'S EMPLOYER _____ PHONE # _____

HUSBAND'S EMPLOYER _____ PHONE # _____

CONTACT PERSONS IN CASE OF EMERGENCY (OTHER THAN SPOUSE)

1. _____ ADDRESS/PHONE # _____
2. _____ ADDRESS/PHONE # _____
3. _____ ADDRESS/PHONE # _____

ALL CHARGES ARE DUE AT THE TIME OF SERVICE. IF SURGERY IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CARDS TO THE OFFICE PRIOR TO SURGERY.

ALL PROFESSIONAL CHARGES RENDERED ARE CHARGED TO THE PATIENT. DIAGNOSTIC RECEIPTS WILL BE FURNISHED UPON REQUEST SO THAT YOU MAY BE REIMBURSED BY YOUR INSURANCE COMPANY.

AUTHORIZATION OF ASSIGNED BENEFITS AND RECORDS RELEASE

I AUTHORIZE DR. THOMAS GIEBMANN TO RELEASE MEDICAL INFORMATION TO SUBMIT INSURANCE CLAIMS AND FOR OTHER PHYSICIAN'S REQUESTS RELATING TO MY MEDICAL CARE. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS FOR ANY UNPAID PROFESSIONAL CHARGES DIRECTLY TO PROFESSIONAL WOMEN'S HEALTHCARE, P.A. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

SIGNATURE

DATE

**CONSENT TO USE OR DISCLOSE INFORMATION
FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS**

The Patient hereby consents to the use or disclosure of her individually identifiable health information (“protected health information”) by Professional Women’s Healthcare, P.A. (“Facility”) in order to carry out treatment, payment or healthcare operations. The Patient should review the Facility’s Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Facility does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice upon request.

Patient retains the right to request that the Facility further restrict how her protected health information is used or disclosed to carry out treatment, payment or healthcare operations. The Facility is not required to agree to such requested restrictions; however, if the Facility does agree to Patient’s requested restriction(s), such restrictions are then binding on the Facility.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective *except* to the extent that the Facility has already taken action in reliance on the Consent.

The Facility may refuse to treat Patient if she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, the Facility has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Signature of Patient

Please print name

Signature of witness

Person signing on behalf of Patient* Please print name

* Please explain Representative’s relationship to Patient and include a description of Representative’s authority to act on behalf of the Patient:

**Authorization for Release of Medical Records
(OPTIONAL)**

(Print Patient's Full Name)

(Date of Birth)

(Address)

(Social Security #)

(City, State, Zip code)

(Home Phone)

At my request, I _____ do hereby authorize Professional Women's
Healthcare, PA to release the following information checked off below:

ALL Medical Information OB Medical Information only GYN Medical Information only

Lab Results Ultrasound Results Pathology Results

Billing /Collections Information Appointments Other _____

I do I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency
Syndrome) or HIV (Human Immunodeficiency Virus), drugs or alcohol.

Information Release To: _____
Name

Address

City, State, Zip

From the time period of _____ to _____.

Signature of Patient

Date

Witness Signature

Date

** It is the patient's responsibility to inform us of any changes.

Welcome to *Professional Women's Healthcare, P.A.* We are honored that you have chosen us as one of your healthcare providers. Our mission is to provide you with top quality care. We look forward to treating you.

Office Hours: For our Dunn location, our office hours are Monday through Friday from 8:30 am to 5:30 pm. We are closed for lunch from 12:30 to 1:30. Surgeries are provided Friday mornings. After hours you may call our office, and our answering machine will either let you leave a message or direct you to call Dr. Giebmanns's pager in the case of an emergency. We will now be seeing patients at our Lillington location on Wednesday afternoons. Please use our main phone number at 910-897-7711 to contact either location.

Patient Information: It is your responsibility to notify us immediately of any change in your name, address, telephone number(s), or health insurance plan(s). It is crucial that we have a way to contact you to confirm appointments and to notify you of any health problems that we may diagnose.

Cancellation and No Show Policy: In respect for our staff and for other patients, we ask that you contact us as soon as possible and at least 24 hours in advance if you must cancel a scheduled office visit. If you fail to call in advance and do not show for your appointment, it will be counted as a "no show." *1st No Show:* The patient will receive a phone call informing her that she has missed her appointment without notifying our office. *2nd No Show:* The patient will receive a letter informing her that she has missed two appointments without notifying our office. *3rd No Show:* The patient will be charged a \$25.00 fee and will receive a letter informing her that her account has been flagged as recurrent no shows and that another missed appointment will result in dismissal from the practice. *4th No Show:* We will no longer be able to serve you.

Health Insurance:

Authorization, Co-Payment and Deductible Payments: If you are a member of a managed care organization, it is your responsibility to obtain an authorization from your primary care physician *prior to your visit*. Failure to do so will significantly delay your visit or may necessitate rescheduling your appointment. Since insurance companies usually refuse to issue a retroactive authorization for office visits, Dr. Giebmanns will be unable to see you unless we have an authorization or you are willing to accept full responsibility for the entire cost of the services rendered. Payment of all co-pays and deductible amounts (when applicable) are required at the time of your visit. For surgeries, we require that you pay these funds by the time of your pre-op visit.

Insurance companies with whom we have a contract: We will file your insurance for you. In return, you or your guardian agrees to assign any insurance benefits payable to Professional Women's Healthcare, P.A.

Delay in insurance payment: If your insurance company does not pay your claim within 45 days of submission, we may forward the bill to you and ask for your assistance in getting the claim paid. If your insurance company does not pay for a legitimate claim within 60 days after submission, we may enlist your help to register a complaint with the insurance commissioner.

Insurance company denials: You (or your guardian) are responsible for being familiar with your health insurance policy benefits and exclusions. Certain benefits may not be covered. For instance, many policies deny coverage for problems relating to infertility and/or preexisting conditions. If your policy excludes benefits for a particular condition and you elect to see Dr. Giebmanns for this condition, you or your guardian are responsible for payment in full for services rendered. Insurance payments may also be denied for other reasons. Our policy is to appeal denied claims. We may ask for your help in disputing a denied claim with your insurance company. However, if a denial is final, you or your guardian agrees to pay the amount due unless the reason for the denial is our fault.

Insurance companies with whom we do not have a contract: As a courtesy, we will file your insurance claim for you. In return, we expect payment in full at the time of your visit for services rendered. If your insurance policy does not offer out-of-network benefits, we offer a discount off our regular fee schedule.

Financial Policy: Payment is required upon check-in. If there is a balance on your account, payment is required prior to being seen again. It is your or your guardian's responsibility to notify our office of any referral authorizations, pre-admission certification and/or second opinion requirements of your insurance company at the time of scheduling office appointments, hospital admissions or surgery. If our office is not notified in advance of these requirements, this document acts as a waiver, and you or your guardian agrees to be responsible for payment of services rendered.

Charge for Copying Medical Records: There will be a charge for copying records that exceed 20 pages in length to cover our expenses for processing and postage. Also, a signed HIPAA release of medical records form will be required before records will be released.

Payment: We gladly accept cash, checks, debit cards and credit cards (Visa and Mastercard only). Please note that we must verify funds in your account for all checks of a substantial amount.

Returned checks: If your check is returned for any reason, a \$25 returned check fee will be assessed, and we will no longer be able to accept checks from you. You will be required to rectify any payments due before your next appointment.

Self pay: As a courtesy to our self pay patients, we offer a discount off our regular fee schedule, which is comparable to the reimbursement we receive from insurance companies. In return, we expect payment in full at the time of your office visit. Surgeries require payment at the time of your pre-op visit.

Surgeries: If you require surgery, we will verify insurance benefits and provide you or your guardian with an estimate of the amount you will be responsible for. This will consist of any deductible you have not met for the plan year in addition to your co-insurance. The estimated amount is due in full **prior** to your surgery at your pre-op visit.

Collection policy: Unless payment arrangements have been made, all "patient due" accounts (once your insurance company has paid its portion of the claim, or from the time of service for self pay patients and patients with insurance companies that we do not participate with) over ninety (90) days old will be turned over to a licensed debt collection agency. In addition to being liable for your outstanding balance, any additional court costs and attorney fees that are required to collect your outstanding balance will be charged to you.

Drug Screening: *In order to protect the health of you and your infant, we may randomly screen any patient for drug use. By signing this form, you consent to being tested.*

Attestation: Your signature or the signature of your guardian acknowledges that you understand and accept the above information.

Patient's Signature

Patient's Printed Name

Date

Guardian's Signature

Guardian's Printed Name

Date

Witness's Signature

Witness's Printed Name

Date

NOTICE OF PRIVACY POLICY

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment, as a means of communication among the many health professionals who contribute to your care, as a legal document describing the care you received, as a means by which you or a third-party payer can verify that services billed were actually provided, as a tool in educating health professionals, as a source of data for medical research, as a source of information for public health officials charged with improving the health of the nation, as a source of data for facility planning and marketing, as a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your record and how your health information is used ensures its accuracy, helps us better understand who, what, when, where and why others may access your health information, and helps us make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect and obtain a copy of your health record, obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, and revoke your authorization to use or disclose health information, except to the extent that action has already been taken.

OUR RESPONSIBILITIES:

This organization is required to maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us with. We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact the privacy officer at 910-897-7711. If you believe your privacy rights have been violated, you can file a complaint with the privacy officer or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EXAMPLES OF DISCLOSURE FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:

We will use your health information for treatment. For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to a treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you are discharged from this hospital.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify a family member, personal representative, or another person responsible for your care, your location, and your general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repair or replacement.

Workers' compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing and controlling disease, injury or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution, or agents thereof, information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes, as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

EFFECTIVE DATE: August 1, 2005



MEDICAL RECORDS REQUEST

Patient's Full Name _____
Any Other Names Patient May Be Listed As _____
Address _____
City, State, Zip _____
Date of Birth _____

I hereby request the following medical records in the possession of the provider, including, but not limited to, records, reports, tests or information concerning mental illness or developmental disabilities, psychotherapy notes, HIV/AIDS testing or treatment, communicable diseases, venereal diseases, substance abuse, abuse of an adult with a disability, sexual assault, child abuse and neglect, genetic testing and abortions (*if you wish to limit the material disclosed above in any way, please indicate exactly what you do not want released*):

Please initial:

- | | |
|---|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Emergency Reports |
| <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Pap Smear Results |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Mammogram Reports |
| <input type="checkbox"/> Ultrasound/X-Ray Reports | <input type="checkbox"/> Discharge Summaries |
| <input type="checkbox"/> Other: _____ | |

For the following dates of treatment: (for example: specific date, range of dates, all dates of service)

be released by Fax or Mail

FROM: (name)	TO: Professional Women s Healthcare, P.A.
(address)	805-B Tilghman Drive
(address)	Dunn, NC 28334
(tel. #)	Tel.: (910) 897-7711
(fax #)	Fax: (910) 897-2654

The purpose of the disclosure is: continued patient care other: _____

***This request is valid for 6 months from date of the above signature. I understand that I may change my mind and revoke this Medical Records Request in writing at any time by notifying the Privacy Officer. I understand that changing my mind will not affect my treatment. The revocation will not apply to the extent that Professional Women s Healthcare has already taken action where it relied on my permission. I understand that I have the right to inspect or copy any information used/disclosed under this authorization. I understand that I may refuse to sign this Medical Records Request, and if I do refuse, my ability to obtain treatment will not be affected unless the only purpose of treatment is to create health information for the disclosure listed above. I have read and understand this Medical Records Request and had a chance to ask questions about the disclosure of health information. I authorize Professional Women s Healthcare, P.A. to use my health information in the manner described above.

X _____
 Signature of Patient Date