WOMEN'S HEALTH SPECIALISTS OF NORTH TEXAS

Demographics Page

PATIENTS NAME: _____
LAST FIRST M

ADDRESS: _____
CITY STATE ZIP

PRIMARY PHONE: _____ **SECONDARY PHONE:** _____

DATE OF BIRTH: ____/____/____ **DRIVER'S LICENSE #:** _____ **MARITAL STATUS:** M /W/ D/ S

SOCIAL SECURITY: _____ **EMAIL ADDRESS:** _____

EMPLOYER: _____ **OCCUPATION:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP** _____ **PHONE #** _____

******Patient portal contact: Voice Text Email all the above*******

PRIMARY ***YOU MUST COMPLETE EACH BLANK AND PROVIDE INSURANCE CARD IN ORDER FOR US TO BILL YOUR INSURANCE***

INSURANCE COMPANY: _____ **PHONE #:** _____

POLICY HOLDER'S NAME: _____ **POLICY HOLDER'S DOB:** _____

POLICY #: _____ **GROUP #:** _____ **RELATIONSHIP TO PATIENT:** _____

SECONDARY** YOU MUST COMPLETE EACH BLANK AND PROVIDE INSURANCE CARD IN ORDER TO BILL YOUR INSURANCE****

INSURANCE COMPANY: _____ **PHONE #:** _____

POLICY HOLDER'S NAME: _____ **POLICY HOLDER'S DOB:** _____

POLICY #: _____ **GROUP #:** _____ **RELATIONSHIP TO PATIENT:** _____

PHARMACY NAME: _____ **PHARMACY LOCATION:** _____

I authorize the physicians and /or qualified staff to perform upon me, ultrasound and/or any other care including treatment necessary for the well being of me and/or my unborn child. I acknowledge that the practice of medicine and/or ultrasound is not an exact science and that no guarantees can be made to me as to the outcome of treatment and/or my pregnancy. I understand during my visit labs deemed necessary by my physician will be ordered.

PATIENT SIGNATURE: _____ **DATE:** _____

I authorize my insurance benefits to be paid directly to Women's Health Specialists of North Texas realizing I am responsible to pay non-covered and/or denied services. In the event that my insurance carrier denies payment for any reason, I acknowledge that I am responsible for payment of services provided to me.

PATIENT SIGNATURE: _____ **DATE:** _____

I authorize the release of information to my insurance carrier named above concerning my medical condition and for the purpose of claims processing. I also authorize the release of medical information to my referring physician and any physician I am recommended to see for continuation of care. I understand that the release of information will only consist of medical records belonging to Women's Health Specialists of North Texas.

PATIENT SIGNATURE: _____ **DATE:** _____

This notice serves as confirmation that a current copy of the Privacy Practices has been reviewed by me and a copy provided should I request it. I understand that my "protected health information" includes health information, including demographic and financial information I have provided or has been received from another health care provider, health plan, employer, or insurance company. This information may include information on HIV, AIDS, alcohol use, drugs and medication. This protected information relates to my present, past and future physical and mental health or condition. I understand that I have the right to revoke or change this authorization, in writing, at any time by providing written notification to the office at the address above.

PATIENT SIGNATURE: _____ **DATE:** _____

WOMEN'S HEALTH SPECIALISTS OF NORTH TEXAS

Patient Preference Regarding Communication of Health Information

Patient Name: _____ DOB: _____

☐ **I hereby give permission to Women's Health Specialist of North Texas to disclose and discuss any information related to my medical condition(s) to/with the following member(s), other relative(s) and/or close friend(s).**

_____	_____	
Name	Relationship	Phone number
_____	_____	
Name	Relationship	Phone number
_____	_____	
Name	Relationship	Phone number

OR

☐ **I do NOT wish to give permission to family members, relatives, or close friends to access to any information regarding my medical condition(s).**

How to Contact (Please check all that apply)

☐ Leave a message on my **HOME-OR-CELL PHONE with detailed information.**

☐ Leave a message on my home phone with a **call-back number only.**

☐ **CONTACT ME REGARDING MY BILL THROUGH EMAIL.**

☐ Mail to my **home address** _____

☐ F**ax to this number**_____

☐ Contact me regarding results via myhealthrecord.com

I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____

Signature of Patient/or Legal Representative **Date**

_____

Print Patient/or Legal Representative

WOMEN'S HEALTH SPECIALISTS OF NORTH TEXAS

FINANCIAL POLICY AGREEMENT

- **Co-payments, deductibles, co-insurance, and/or global OB fees are due at the time of service.** We accept Cash, Personal Check, Care Credit, MasterCard, and Visa. If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due ***prior*** to these services being provided. Any remaining balance after your health plan pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will be notated as private pay and payment will be due in full. *Account balances over 90 days with no payment activity will be reported to the credit bureau(s).* Initials _____
- **Your insurance policy is a contract between you and your insurer. It is your responsibility to know what your policy covers and what it does not. Some insurance policies DO NOT cover everything or pay 100%.** Any item deemed "non-covered" by your insurance carrier will be your financial responsibility. This includes lab designation and payment. Any disputes about payment must be resolved between you and your insurer. You are responsible for ensuring a properly dated referral and/or authorization if required by your insurer for services being provided. You are also responsible for payment if your claim denies for lack of referral/authorization. Failure to provide accurate insurance information within 3 days from the date of service will result in the balance becoming your financial responsibility. Initial _____
- As a courtesy to you, we will file any verified primary and secondary insurances for you with proper assignment and only if presented at the time of your visit. Please bring your insurance cards with you to every visit. I understand that all remaining balances are my responsibility to satisfy prior to additional services being rendered. Initial _____
- This office is not party to legal disputes. The financial responsibility rests with the patient or parent/guardian for patients under 18 years of age. Initial _____
- A $35.00 fee will be assessed for all returned checks. Initial _____
- We confirm appointments 48 hours in advance. Please notify our office within 24 hours before scheduled appointment to avoid a $25.00 cancellation fee. Initial _____
- Payments & credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service. Refunds over $50 will be provided within 30 days from the date all outstanding claims are satisfied. Credit balances less than $50 will be available and processed upon request of the patient. Initial _____
- Well Women Exam is preventative care only. If other medical conditions or issues during a WWE an office visit will be billed along with WWE. Initial _____

ASSIGNMENT OF BENEFITS

I request payment of the medical benefits, otherwise payable to me, directly to *Women's Health Specialists of North Texas* for services provided by them.

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 at any time.

_____ _____

Responsible Party Printed Name (Must be 18 or over) Date

_____ _____

Responsible Party Signature (Must be 18 or over) Date

WOMEN'S HEALTH SPECIALISTS OF NORTH TEXAS

CONSENT TO TREATMENT OF A MINOR

I_____, parent/legal guardian of the patient, _____DOB: ___/____/___, authorize the physician(s) of Women's Health specialist of North Texas to evaluate and treat my minor child for any medical treatment determined by a physician to be necessary for her health and welfare.

I understand I must provide a copy of my current Driver's License and that I assume full financial responsibility for all services rendered and deemed patient responsibility by my daughter's insurance carrier and those outlined in the Financial Policies for which I have signed. _____ Initial

☐ After initial visit, my child can come in without an adult for treatment deemed necessary **(consent for additional treatment such as IUD/Nexplanon or surgical procedures will need to be signed by parent/legal guardian prior to visit)**

OR

☐ In my absence, my child **must** be accompanied by:

_____relationship_____

_____relationship_____

_____relationship_____

I understand that this consent will remain in effect until the patient becomes of legal age to consent on her own.

Signature of parent/legal guardian:_____Date:_____

Staff member:_____Date:_____

WOMEN'S HEALTH SPECIALISTS OF NORTH TEXAS

SELF INSURED AGREEMENT

You have represented to *Women's Health Specialists of North Texas (hereinafter "Practice")* that you are self-insured (i.e. do not have health insurance that covers obstetrics & gynecology) for the following date(s)_____. By representing yourself as a self-insured patient, you:

(1) are asking that the Practice not file any documents with an insurance company.
(2) will pay at the time of service.
(3) will receive a "prompt pay" discount off the regular price; and
(4) are waiving any medical insurance benefits that you might have (understanding that if you do have health insurance, your insurance company might refuse to cover your services based on this wavier).

Women's Health Specialist of North Texas is only requiring you to make payment at the time of service based on your representation. Further, the Practice is only extending the "prompt pay" discount based on your representation. If your representation is false, you will be liable to the practice for any and all losses, expenses and/or damages incurred by Women's Health Specialists of North Texas.

_____ _____

Responsible Party Printed Name (Must be 18 or over) Date