WOMEN'S HEALTH SPECIALISTS OF NORTH TEXAS

PATIENTS NAME: _____
LAST FIRST M

ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP**: _____

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

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

SOCIAL SECURITY:_____**EMPLOYER**: _____

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

EMAIL ADDRESS: _____

PRIMARY INSURANCE ***IF YOU WOULD LIKE US TO BILL YOUR INSURANCE, YOU MUST COMPLETE EACH BLANK

INSURANCE COMPANY:_____

POLICY HOLDER'S NAME:_____ **DATE OF BIRTH**:_____ **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.

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**: _____

The duration of this authorization is indefinite unless otherwise revoked in writing.

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)

_____ OK to 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.**

_____ **OK TO CONTACT ME REGARDING MY BILL THROUGH EMAIL.**

_____ OK to mail to my **home address** _____

_____ OK to **fax to this number**_____

The duration of this authorization is indefinite unless otherwise revoked in writing. 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

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

I understand that this consent will remain in effect until I submit a change in writing or 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

FINANCIAL AGREEMENT PAGE TWO-SIGNATURE

By signing this, you have received the Financial Agreement, page one.

- **Co-payments, deductibles, coinsurance 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. Do not assume your policy covers everything or pays at 100%. It is your responsibility to know what your policy covers and what it does not. We cannot quote your benefits.** 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 primary participating insurance for you with proper assignment. Any additional insurance policies will be yours to file with receipt from our office. Please bring your primary insurance card 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 _____

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

SELF INSURED PAYMENT 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 of 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

WOMEN'S HEALTH SPECIALISTS OF NORTH TEXAS

HOURS M-F 8-12 & 1-5

FINANCIAL POLICY

We are doing everything possible to hold down cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance by our billing department. This includes applicable co-insurance and co-payments for participating insurance companies. We accept cash, personal in-state checks, VISA and MasterCard. **OB prenatal payments will be due in monthly/weekly payments, per the OB fee sheet, by the 28th week of pregnancy. These funds will be distributed once the claims are processed as insurance requires us to bill Globally.** There is a **$35.00 service charge** for all returned checks. Worthless checks will be forwarded to the **Hot Check Division** of the county in which it was written if not resolved in **five business days. If you pass a worthless check for a visit the prompt pay discount will be forfeited. Stop payment on a check written to our business will result in small claims court. All discounts will be lost as prompt pay is set aside for monies being available that day.**

INSURANCE AND STUDENT STATUS

We bill **primary** participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within **45 days** of the date of service, you will be expected to pay the balance in full. You are responsible for all charges.

OUR OFFICE WILL NOT FILE SECONDARY INSURANCE UNLESS AUTOMATICALLY FORWARDED BY YOUR PRIMARY.

Please note once you start your care as **private insurance** you will stay private insurance **OR** become **self pay**. We will **NOT** file Medicaid if you lose your private insurance.

You must provide an insurance term letter at our request. Regarding health spending accounts: Payment/deductible/co-insurance is due at time of service unless the funds are immediately available (i.e. Credit Card attached to the account). If you do not provide the correct order of your insurance/insurances, you will be responsible for the entire balance as we are held to a 90-day timely filing contract. Example-you are covered by your parents/spouse and you have insurance as well. It is your responsibility to inform us of your primary

PAYMENT OF BALANCE/COLLECTION AGENCY

All outstanding accounts with Women's Health Specialists of North Texas MUST be paid in full before an appointment will be made. Please understand if one member of the family is in collections that balance must be paid prior to any services rendered to another family member.

You will receive your first statement once we have received the payment from your insurance. We will apply this to the dates of service the payment was intended. If there is a balance due a payment plan will be set up for you.

If a payment is missed it may be necessary to forward your account to an Outside Collection Agency.

REFUNDS and MEDICAL RECORDS

Overpayments must be requested in writing. Refunds require 30 days to process. Medical records will be processed in 48-72 hours once the release form is received by our office. Please note due to conflict you are NOT allowed to switch physicians in the middle of ongoing care such as pregnancy or other surgical care.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late cancelled appointments. ***Excessive abuse of missed/late cancelled appointments may result in dismissal from the practice.***