Obstetrics Gynecology Family Practice

Date: ________________

Name: (Last) ____________________________ (First) ________________________________ (MI) _____

Address: ____

City: ________________________________ State: ________ Zip: __________________

Birth Date: ___________ Phone: ________________ Work: _______________ Cell: _________________

SSN: _______-_______-_______ Language: ____________________

Primary Insurance: ____

Insured Party: Self Spouse Parent Other Group #:__________________ ID #:__________________

Name of Insured (If other than self): ____

Birth Date (Insured Party): ___________ SSN (Insured Party): _________-________- ___________

Address (if different than Self):____

City: ________________ State: ____________ Zip: ____________________

Phone: ____________________ Work: _______________________ Fax: ____________________

Secondary Insurance: ____

Insured Party: Self Spouse Parent Other Group #:__________________ ID #:__________________

Name of Insured (If other than self): ____

Birth Date (Insured Party): ___________ SSN (Insured Party): _________-________- _________

Address (if different than Self):____

City: ________________ State: ____________ Zip: ____________________

Phone: ____________________ Work: _______________________ Fax: ____________________

Primary Care Physician (PCP): ____

Facility Name: ______________________________ Phone: ______________ Fax: ________________

How did you hear about us? Friend Doctor Radio Other : Please list _____________________________

Emergency Contact: ____

Telephone: ________________________________ Relationship: _____________________________

S. Diaz, M.D.
J. Carpenter, M.D.

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_______ **Consent to the use and Disclosure of Health Information for Treatment, Payment, or Health Options**
Initial

I understand that as part of my healthcare, Complete Care Center for Women, LLC originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for the future care or treatment. I understand that this information serves as:

- ❖ Basis for planning my care and treatment
- ❖Means of communication among many health care professionals who contribute to my care
- ❖Source of information for applying my diagnosis and surgical information to my bill
- ❖Tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the practice reserves the right to change their notice and practices without notice and may mail any revised notices to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

I, ______________________________, understand that it is the policy of Complete Care Center for Women to restrict access to my Protected Health Information. My health information may be disclosed to caregiver(s) providing health services, insurance company(ies) for payment of my claim, and basic healthcare operations such as pre-certifications, referrals, etc.

Communication:

❑ **I do not release authorization for any confidential clinical/financial information to be given to anyone but me**
❑**You may leave confidential clinical/financial information on my answering machine or voice mail.**
❑**You may leave confidential clinical/financial information on the following additional methods of communication, ie cell phone, voice mail at work, or you may send written communication to the address or fax number below:**

____

I give permission for the following person(s) to have access (as indicated below) to my Private Health Information.

INFORMATION ACCESS PREFERENCES					
NAME (PLEASE PRINT)	DOB	CLINICAL		FINANCIAL	
		☐ All	☐ None	☐ All	☐ None
		☐ All	☐ None	☐ All	☐ None
		☐ All	☐ None	☐ All	☐ None

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______ **Release of Information Guidelines**
Initial

HIPPA Rules – The information belongs to the patient, the medical record belongs to whomever originated it.

In accordance to the Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Options form signed and dated by the patient, the charge for releasing information for purposes other than referring doctor will be as followed:

Copy and retrieval fee: $10.00
First 50 pages: $0.50 / page
All other pages thereafter: $0.25 / page
Ultrasound, X-Rays, microfilm pictures, etc: $1.00 / item
Shipping and handling charges will be applied if necessary

*Please allow up to 15 days to receive information

______ **Instructional Facility**
Initial

Complete Care Center for Women is an instructional facility responsible for educating the Chesterfield Family Practice Residents. These Residents are professional and licensed medical physicians who are supplementing their knowledge in OB/GYN under the supervision of Dr. Diaz and/or Dr. Carpenter. You may be seen by a Resident during your scheduled visit.

______ **Authorization to Release Information and Assignment of Insurance Benefits**
Initial

❑ Do Not File a Claim for Me

❑ File a claim for me. I authorize payment of medical benefits directly to: Complete Care Center for Women, LLC. I hereby authorize the release of any medical information to the insurance company(ies) listed on my registration form in order to process any claims. I further authorize copies of this authorization to serve in place of an original.

______ OUTSTANDING BALANCES
Initial

We urge you to keep your account current to avoid any misunderstandings with our office. All account balances past due over 120 days will be sent to an outside agency for collections. At that point, the account is out of our hands. If you need to make special arrangements, it is your responsibility to contact Commonwealth Medical Management (CMMS) before your account is sent to an outside agency.

Accounts sent to an outside agency/Attorney will be assessed 33% to the total balance plus any additional cost, court or legal fees that may occur as a result of your delinquency.

In the event your account is sent to an outside agency, you may be suspended from the practice and no additional appointments will be scheduled until your account has been cleared. If your account is forwarded to an outside agency, you may also run a risk of being discharged from the practice and be required to transfer your care to another provider.

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______ FINANCIAL POLICIES AND PROCEDURES
Initial

Complete Care Center for Women is dedicated to providing you the most efficient care and service possible. Your understanding of our financial policy is an essential element of your care and service. If you have any questions regarding any aspect of our policy, please feel free to present your question to any member of our staff. Full payment is due at the time of service. If you have insurance, and have signed an "Assignment of Benefits" statement, we will bill your insurance carrier for you if we are a contracting provider with your plan.

We believe that all patients who come to this office deserve the best medical care that can be provided. In order for us to provide you with the highest quality medical care and current technology, we must insure that we are able to meet the expenses necessary to operate this facility. To ensure that these expenses are met, we provide you with this agreement to acquaint you with our financial policy.

______ PAYMENT AT TIME OF SERVICE
Initial

As a courtesy, we will bill your insurance for all office visits. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays. We ask that you pay any portion not covered by your insurance due to deductibles or co-payments on the day of service, unless otherwise specified in the policies of Complete Care Center for Women. This includes all office visits, procedures, and injections.

If you are unable to pay your co-pay or co-insurance, you may be asked to reschedule your appointment unless other arrangements have been made with the Office Manager prior to your scheduled appointment. Please remember . . . Your insurance coverage is a contract between you and your insurance company and not a substitute for payment.

Under special circumstances, payment arrangements can be made. These arrangements are made with the Office Manager prior to you being seen. Our office may set this up for you as a courtesy depending on the circumstance. You will be sent a monthly statement. However, it is your responsibility to know your monthly due date, which will be determined at the time your payment arrangement is contracted. After one missed payment, your arrangement will be voided and the account will be sent to an outside agency for collections.

______ PATIENT RESPONSIBILITY
Initial

It is your responsibility to know the details of your particular insurance policy. Not all services are covered by all carriers. Services which are not covered by your insurance are your responsibility.

Diagnoses and services are carefully documented to comply with federal law. Under no circumstances will these be changed, altered or falsified in order to obtain coverage by insurance.

If your insurance has a co-payment policy, the co-payment is due at the time of service. If you have a deductible, you are responsible for all charges until the deductible is met. In the event Complete Care Center for Women is a contracted provider, you are responsible for any and all allowable charges which remain after your insurance has paid its portion.

If your insurance carrier has a "network" of providers, it is your responsibility to make sure that we are an "in network" provider prior to obtaining services. If we are not "in network," we will still be happy to provide services; however, the percentage of charges for which you are responsible will typically be greater.

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If your insurance has designated a primary care physician (PCP), you are required to have a valid referral from your PCP prior to your visit. If a valid referral is not provided, you will be asked to either reschedule your appointment or pay in full for the services incurred on that day.

It is also your responsibility to make us aware of any restrictions your policy has on ancillary services (such as requiring a specific lab).

It is your responsibility to make sure we have accurate insurance carrier information and billing information. If a claim is unsuccessful because of flawed insurance or billing information, you will be responsible for the balance.

It is your responsibility to ensure that the providers of Complete Care Center for Women are contracted providers with your insurance plan prior to your visit. If claim/s are denied due to non-contractual provider, you are responsible for all charges on the services rendered.

We will make every effort to assist you in understanding the above information. We will also assist with any problems arising with your insurance to the extent we can accommodate.

______ APPOINTMENT POLICY
Initial

We will work hard to accommodate appointments that fit your schedule and medical needs. We ask that you let us know about cancellations or changes twenty-four hours in advance. Habitual missed appointments are grounds for dismissal from the practice.

Failure to contact the office within 24 hours of your scheduled appointment to either cancel or reschedule, will result in a no show fee of $50 for the missed appointment.

______ SELF PAY ACCOUNTS
Initial

Self pay accounts are patients that have no insurance coverage, have not met their deductible or are covered by non-participating insurance plans. Payment must be made at the time of service. If this is not possible, please discuss the situation with the Office Manager before your scheduled appointment.

Payment plans with balances over 60 days old will accrue a finance fee of 2% per month.

______ BILLING PROCEDURE
Initial

Once your claim/s are filled with your insurance company and payment or denial is received, you will receive a statement informing you of the balance you are responsible for paying. If there is a remaining balance due after your insurance carrier pays, you have 30 days to make payment on the invoice. Payment arrangements can be made for special circumstances by contacting Commonwealth Medical Management (CMMS) at (804)740-8000 or the number printed on your statement within 15 days of the receipt of the invoice. It is your responsibility to make contact with CMMS to make special arrangements.

Any accounts past due over 60 days will receive a late fee of $25 and a monthly finance fee of 2% per month on the total balance.

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______ RETURNED CHECK FEE
Initial

Any checks returned will be assessed an additional fee of $50 to the amount of the check.

By signing below, I agree to the terms listed above.

________________________________ _______________
Signature of Patient/Legal Guardian Date

CCCW RESERVES THE RIGHT TO REFUSE SERVICE TO ANY PATIENT WHO DECLINES TO AGREE TO THE TERMS ABOVE

Virginia Law requires that we inform you of the following:

The patient is hereby informed in accordance with Section 32.1-45.1 of the Code of Virginia 1950, amended, that if the provision of health care to the patient at Complete Care Center for Women LLC, directly exposes any person employed by or under the direction and control of Complete Care Center for Women, LLC, or any other health care provider, to the patients body fluid in a manner which may transmit immunodeficiency virus or HIV and to the release of such tests to the person(s) exposed.

Non-Medical Translation:

If an employee of Complete Care Center for Women, LLC. is exposed to your bodily fluids during a procedure (i.e. an accidental needle stick). Complete Care Center for Women, LLC. has the right to check you (patient) for HIV- for the safety/protection of our employees. You do not have to be informed of your results if you do not want to know.

I have read/been informed of the contents of the foregoing notice.

Patient Name (Print):_____________________ Signature: _____________________ Date:___-______

Translator Name (Print): _________________ Signature: _____________________ Date:_________

Witness (Print): _________________________ Signature: ______________________ Date: ________

Patient Representative's Acknowledgement of Notification Where Patient is Unable to Sign:

I, _______________________________, am the _______________________ of the above name, and on
(Name of patient representative) (Describe Relationship)
behalf of the patient, I hereby acknowledge that the patient has been given the foregoing notification concerning Section 32.1-45.1 of the Code of Virginia 1950.

Signature of Representative: ________________________________ Date: ___________