



Women's Health for Life, Inc.

1005 Bellefontaine Ave., Suite 175
Lima, OH 45804

770 W. High St., Suite 400
Lima, OH 45801

MINOR PATIENT INFORMATION

Date: _____

Please Print all Information

Name: _____
Last name First name Middle

SSN: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone: _____ Cell: _____ Separated ___ Divorced ___

Sex: ___ M ___ F Age: _____ Birthdate: _____ Married ___ Widowed ___

___ Single ___ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

GUARANTOR INFORMATION

Person or guardian who brings child is responsible for payment

Person Responsible for Account _____
Last name First name Middle

Relation to Patient _____ Birthdate _____ SSN: _____

Address (if different than patient) _____ City _____ State _____ Zip _____

Phone _____ Cell _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

***We are unable to provide treatment to the patient (s) without the consent of a legal parent or guardian. Please sign below to give your consent to have the patient treated with and without your presence.**

Signature _____

Date _____



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INSURANCE INFORMATION

Is patient covered by additional insurance? ___ Yes ___ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different than patient) _____ City _____ State _____ Zip _____

Phone _____ Cell _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ SSN: _____

Member # _____ Group # _____

Names of other dependents covered under this plan _____

SECONDARY INSURANCE

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different than patient) _____ City _____ State _____ Zip _____

Phone _____ Cell _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ SSN: _____

Member # _____ Group # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am fully responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits or the payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please Print name of Patient, Parent, Guardian or Personal Representative

Date



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HIPAA PRIVACY NOTICE CONSENT FORM

By signing this form I acknowledge that I have received and read the patient Notice of Privacy Policy, Financial Policy and HIPAA Notice and my signature acknowledges my understanding.

HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION:

Please choose one of the following:

_____ Patient ONLY ****OR****

_____ You may disclose my medical information to:

_____	_____	_____	_____
Please release info to: Print name	Relationship	Phone number	DOB

_____	_____	_____	_____
Please release info to: Print name	Relationship	Phone number	DOB

_____	_____
Patient Signature OR Parent/Guardian of Minor Patient	DOB

**CONSENT EXCEPTION FOR TREATMENT TO A MINOR PATIENT
(14 YEARS OLD TO 18 YEARS OLD)**

Your parent or legally appointed guardian has allowable access to all your medical information, healthcare concerns and diagnoses, these will be discussed without consent with the **exception** of:

I **DO** authorize the release of the below information _____

I **DO NOT** authorize the release of the following: _____

_____ Sexually transmitted diseases results (STD's)

_____ Drug, alcohol or substance abuse

_____ Pregnancy

_____ Minor (14-18 years old) signature/ Printed name

_____ Date



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Patient Notice-Of-Privacy-Policy (To be given to all patients)

What you need to know about the Confidentiality Policy

Women's Health For Life, Inc. is committed to providing you with high quality health care and to forming a relationship with you that is built on **trust**. That means respecting your **privacy** and **confidentiality** of your medical information. We protect your privacy and confidentiality rights by creating and putting into practice policies and procedures that allow access to your personal medical information **only** for legitimate reasons.

Your medical record

As we provide your health care, we are required to maintain a complete copy of your medical history, current condition, treatment plan, and all treatment given, including the results of all tests, procedures, and therapies. Whether this information is stored in writing, on a computer, or other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality. Of course, the physicians and other health care professionals who are involved in your care need to access this information in order to provide appropriate treatment for you.

Your medical information is private and confidential

You, or anyone whom you give written permission, or your legal representatives, have the right to read or get a copy of your medical information. Your medical record is the physical property of Women's Health For Life, Inc.

How do we assure your privacy?

Women's Health For Life, Inc. has put in place detailed policies regarding access to medical records by our staff and employees and has carefully outlined the circumstances under which your medical information may be released to parties outside Women's Health For Life, Inc. These policies conform with state and federal law and are designed to safeguard your privacy. Our staff and employees are trained in the appropriate use of medical information and know that it is available to them only to continue to provide care to you or for other limited but legitimate reasons. A violation of confidentiality or the failure of an employee to protect your information from accidental or unauthorized access will not be tolerated. This may include the employee being fired from her job.

We ask for your permission

We do not allow others outside Women's Health For Life, Inc. to access your medical information unless we have the appropriate authorization to do so. We will request your authorization to release information at your first visit. In addition, some laws prevent certain types of patient information from being released without specific patient permission. Examples include, but are not limited to:

- Confidential details of:
 - Psychotherapy (from records of my treatment by a psychiatrist, licensed psychologist, or psychiatric clinical nurse specialist)
 - Other professional services of a licensed psychologist
 - Social Work Counseling/Therapy
 - Domestic Violence Victims' Counseling
 - Sexual Assault Counseling
- HIV test results (Patient authorization required for **EACH** release request.)
- Records pertaining to Sexually-Transmitted Diseases
- Alcohol and Drug Abuse Records

Please note, however, that the law requires some information to be disclosed in certain circumstances. This includes mandatory reports of abuse of children or elderly or disabled persons. Also, subpoenas or court orders may compel the disclosure of confidential or privileged health information in the context of a lawsuit or administrative proceeding. Medical records are sometimes used for reasons other than patient care. For example, records are periodically reviewed to evaluate the quality of care, or to be sure that it follows the rules of regulatory agencies for the efficient and effective utilization of care such as Medicare, Department of Public Health, or Department of Mental Health. Your insurance company may request information that we are required to submit in order to provide and bill for your care. Anyone reviewing records must follow the same confidentiality laws and rules required of all health care providers. Patient records are valuable tools used by researchers in finding the best possible treatments for diseases and medical conditions. All researchers must follow the same rules and laws that other health care workers are required to follow to insure the privacy of patient information. Information that may identify you will not be released to anyone outside Women's Health For Life, Inc. without your written approval. In all research conducted within Women's Health For Life, Inc., concern for your privacy and well-being is our first priority.

If you have questions... If you have questions about the privacy of your medical records, please speak with your physician or the office manager, as appropriate. We will be happy to help you.

Patient Name: _____

Are you sexually active? Yes ___ No ___

Age of first sexual encounter _____ Number of partners (Lifetime) _____

History of sexually transmitted disease? Yes ___ No ___ What _____ When _____

Did you receive treatment? Yes ___ No ___

Are you using birth control? Yes ___ No ___ Method? _____

Problems with current birth control? _____

Vasectomy? Yes ___ No ___ Tubal ligation Yes ___ No ___

Do you perform self breast exams? Yes ___ No ___ Last mammogram? _____ normal abnormal

Last pap smear _____ normal abnormal History of abnormal pap smear? _____

Last bone density study/Dexa scan _____ normal abnormal

Last Colonoscopy _____ normal abnormal

If you are postmenopausal:

Are you on hormone replacement? Yes ___ No ___

If yes what? _____

Did you have a hysterectomy? Yes ___ No ___

Do you have your ovaries? Yes ___ No ___

Do you get immunizations? Yes ___ No ___

Last flu shot _____ Last pneumonia shot _____ Shingles vaccine _____ Other _____

Have you had chicken pox before? Yes ___ No ___ Have you had the chicken pox vaccine? Yes ___ No ___

Last Tetanus/Diphtheria/and Pertussis vaccine _____

Medication name	Strength	How often?	Why are you taking this medication?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you experiencing any of the following symptoms/or having any problems with the following:

Yes No

How much do you smoke? _____

How much alcohol do you drink? _____

Do you use or have you used IV/illegal drugs? _____

Which drugs? _____

Other information you would like us to know:

Ears, eyes, nose, throat, or neck problems		
Appetite changes/weight loss/gain		
Infection/recent illness		
Breathing or heart problems		
Abdominal pain, bowel changes		
Skin problems, joint or muscle aches		
Memory loss or headaches		
Menstrual periods/female organs/breast problems		
Low energy/fatigue		
Urinary symptoms		
Abnormal bleeding		
Hot flashes/night sweats		
Hair growth		
Pelvic pain with intercourse		
Weight loss/gain		
Chills/fever		
Cold symptoms		

Patient Signature: _____

Clinical staff initials _____

Practitioner initials _____



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Name (print): _____ Date: _____

How would you like to receive NORMAL lab/pap/x-ray results?

- E-Mail—E-Mail address: _____
- Mail
- Text—Cell phone Number: _____ - _____ - _____

Cell phone carrier: **(Circle one)**

- ❖ AT & T—number@txt.att.com
- ❖ Verizon—number@vtext.com
- ❖ Alltel—number@message.alltel.com
- ❖ T-Mobile—number@tmomail.com
- ❖ Sprint—number@messaging.sprintpcs.com
- ❖ Virgin Mobile—number@vmobl.com
- ❖ Boost—numbr@myboostmobile.com

New guidelines from the American Medical Association in conjunction with the Center for Disease Control and the Federal Government require physician's office to ask the following information. Certain sub-populations of patients are at risk for certain diseases just because of Ethnicity.

Please complete the following questions:

Language Spoken Primary: _____ Secondary: _____

Race (check one please):

___ Indian ___ Asian ___ Hispanic ___ African American ___ Latino ___ White

Ethnicity: Hispanic or Latino ___
Non Hispanic or Non Latino ___

Women's Health for Life, Inc. Financial Policy

We are committed to providing you with the best possible care. We need your acknowledgement and understanding of our office's financial policy. Please read and initial each section. We do reserve the right to refuse to treat you for unwillingness to sign our financial policy. This document is designed for full disclosure of fees that you may incur while being a patient in our office. A copy will be given to you to keep.

- A- **Valid Insurance** is required to submit your claims for payment. Payment is due at the time of service if you are unable to supply us with your valid insurance card. These visits are not submitted to insurance at a later date. This includes Ohio Medicaid in most cases. You must come prepared with all insurance information. _____
- B- **Co-payments** are due at the time of service. If you do not have your copayment with you at the time of service, we reserve the right to reschedule you. **We do charge an additional billing fee of \$10.00** if we must bill you for your copayment. It is your responsibility to know what your copayment is if it is not listed on your insurance card. _____
- C- **Deductibles/Co-insurance**- You will be billed for any amounts over and above your copayment. A reasonable payment plan will be accepted to pay off these remaining balances. Your payment plan cannot exceed 6 months unless other arrangements are made with our office. Once your account becomes delinquent, we do send it to an outside collection agency to collect payment within 90 days of your first notice of delinquency. Should collections or legal action be necessary on your account, we do reserve the right to charge you for any applicable collection fees or legal fees as a result of this process. This amount will not exceed 30% and will only be the cost of the actual fee to collect the debt. _____
- D- **Non-Covered Services**- We do our best to make sure you are aware if services will not be covered by your insurance, but sometimes we don't know this. While the filing of insurance claims is a courtesy to you, you are responsible for payment for services rendered to you from the date of service. Please make sure you check with your insurance before having any testing performed to be sure it is a covered benefit. We do not do retro determination of benefits. All charges are your responsibility from the date services are rendered to you. If your claim is not paid after 90 days, you will be billed and it will be your responsibility to pay. _____
- E- **Yearly Exam** – Most insurance companies pay for one annual visit in a 12 month period. This includes preventative services at your family doctor as well as our office. Please let our staff know if you have had a prevention visit this calendar year to avoid duplication of services. Visits outside the frequency limitations on your plan will be your responsibility to pay _____ additionally, if you have a problem addressed at a yearly visit that is outside the scope of a preventive service, this will be billed separately to your insurance. If denied on same date of service or if a copayment applies you will be billed for this. We will provide this service the same day as a courtesy to you; however you will be responsible for payment. _____
- F- **Surgeries**- Our billing department will check with your insurance company for coverage on the procedure you are having done. We will estimate how much your responsibility to pay will be. A deposit is required prior to surgery if deductibles are not met, as well as a payment agreement for any remaining patient balance. Checking your benefits does not guarantee payment. You are ultimately responsible for payment. If your insurance company does not pay within a reasonable time, you will be billed for services. Self-pay patients must pay for the procedure, in its entirety, before it can be done. We do accept cash, check, major credit cards and care credit as forms of payment. _____
- G- **Obstetrical Services**- After your first OB assessment visit, we will contact your insurance company and verify your benefits. Our fee for your maternity care will be billed to your insurance company AFTER your delivery if your plan does global (all inclusive) maternity billing. You will have an estimate for any expected out of pocket costs. This fee includes all of your regularly scheduled prenatal visits, the delivery and your six week postpartum checkup. HOWEVER, ultrasounds, non-stress tests, lab and non-pregnancy related office visits are billed separately and will require separate copayments/deductibles. We will set you up on a payment plan for your estimated out-of-pocket expense. You can pay it all at once or make payments. Any amounts for non-included services will be billed to you separately. We will reimburse you for any over payment that we may receive. You MUST notify our office immediately of any changes in your insurance plan or benefits. We must have satisfactory payments on your account each month or it may impact the practice's ability to continue to provide care for you. Should your plan be a non-global plan, we will do our best to split bill your care to maximize your benefits. _____
- H- **Broken Appointments**- Our office does charge for any broken appointment. A broken appointment is failure to call to cancel or reschedule at least 4 hours prior to your appointment time. This fee will range from \$20.00 to \$100.00 depending on the type of appointment or procedure scheduled. In the event of a third missed appointment you will be dismissed from the practice. _____
- I- **Additional fees you should know** Leave of absence forms \$10.00, Return Check fee of \$35.00, Phone consultation without an appointment \$25.00, Work or School Physicals \$40.00, Tax Statement \$10.00, Refill or new prescription outside of an appointment \$10.00, After hours or weekend visits in office are an additional fee of \$75.00, Emergency visits during office hours in the office are an additional fee of \$45.00. Rebilling fee (if applicable) 3% of total patient balance on account after 90 days _____

AUTHORIZATION AND ASSIGNMENT

By signing below, I acknowledge acceptance of all of the above terms of payment as outlined in this agreement and initialed by me.

I authorize the release of any medical or other information necessary to process my medical claims as requested by my insurance. I also authorize and request that payment of benefits be made directly to Women’s Health For Life, Inc. I understand that this authorization will remain until I withdraw the authorization in writing. I have read and understand the above Financial Policy and all of my questions have been answered. I understand that changes can be made to this at any time and I will be notified. I understand that this is a legal document and can be submitted in the event of collections. I also understand that payment of all services rendered is ultimately my financial responsibility in all cases and must be paid in a timely fashion. I also understand that diagnosis codes or procedure codes cannot and will not be changed just to receive payment for services rendered. Codes will only be changed in the result of an error by the providers at Women’s Health for Life, Inc. and after complete review by our coding department. By signing this authorization it is a blanket authorization for those reviews of my medical record should they be necessary.

For Questions regarding this notice, please contact:
Business Office at 419-224-0084

Patient or Responsible Party (PLEASE PRINT) Date of Birth

Signature of Patient/Responsible Party if patient a minor

Staff Reviewer Signature