Women's Health Services of Maryland

(Please print all information & fill form out completely. Thank You.)

PATIENT INFORMATION

LAST NAME_____FIRST NAME_____MI_____

DATE OF BIRTH_____AGE_____SEX_____SS#_____

ADDRESS_____APT#_____

CITY_____STATE_____ZIP_____

CELL PHONE_____HOME PHONE_____WORK PHONE_____

EMAIL ADDRESS_____

(Please provide us with an email to send you appointments reminders and enroll you in our online medical records.)

EMPLOYER_____EMPLOYER PHONE_____

MEDICAL INFORMATION

REASON FOR TODAY'S VISIT_____MEDICAL PROBLEMS_____

ALLERGIES_____MEDICATIONS_____

FAMILY HISTORY_____TOBACCO USE (per cig or pack/day)_____

PHARMACY OF CHOICE_____

EMERGENCY CONTACT/LEGAL GUARDIAN/RESPONSIBLE PARTY

CONTACTNAME_____PHONE#_____RELATIONSHIP_____

INSURANCE INFORMATION

INSURANCE CARRIER_____ SUBSCRIBERS DOB_____

POLICY NUMBER_____PHONE_____

POLICY HOLDER'S NAME_____RELATIONSHIP_____

GROUP NUMBER_____EFFECTIVE DATE_____

How did you hear about us? _____

I hereby authorize payment of any medical insurance benefits for which I am entitled to be made directly to the above provider. I agree to pay the balance of any charges not paid or covered under my insurance plan. I also authorize release of any medical information necessary to process any and all claims to Women's Health Services of Maryland L.L.C and MTBC, Inc. as the billing agent. I realize that any account not paid within thirty (30) days could be subject to a Bill process fee of $1.00 per month and/or interest of 12% per annum. I realize that I am financially liable for these fees unless disputed with the provider or their billing agency. **Cancellation policy: All cancellations or no shows to appointments with less than 48 hours notice is subject to 30 dollars charge, cancellations/no shows for ultrasound appointments with less than 48 hours notice is subject to 30 dollars charge. Patients with 3 no shows or cancellations with less than 48 hours notice may be discharged from the practice. If you are more than 15 minutes late to your appointment we reserve the right to reschedule your appointment.**

If you require a procedure, the practice will contact your insurance company to confirm eligibility and an estimate of your covered benefits. Prior to the procedure, you are required to PAY IN FULL for your estimated out –of-pocket expense related to the procedure if your deductible is above $500. Such amounts may be paid by credit card. Any remaining balance is DUE within thirty (30) days of our receipt of payment from your insurance company. This balance may be charged to the credit card you have provided to us and you will be REQUIRED to sign an authorization allowing us to charge your credit card for this purpose. ANY credit balance will be refunded to the responsible party within (30) days of our receipt of payment from your insurance company.

Patient Signature_____Date_____

Women's Health Services of Maryland, LLC.

Use and Disclosure of Protected Health Information
Section I: PATIENT ACKNOWLEDGEMENT & CONSENT FORM

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Women's Health Services of Maryland, LLC may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices states that we reserve the right to change terms described. Should this happen we will display the new policy and effective date at each of our Women's Health Services Locations.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you.

*By signing below, you acknowledge receipt of our **Notice of Privacy Practices**.*

_____

Patient's Signature Date

_____

Print Full Name

Section II: CONSENT FOR USE AND DISCLOSURE OF INFORMATION

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Women's Health Services, LLC, LLC for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits for related services. I agree to provide all reference and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

_____

Patient's Signature Date

_____

Print Full Name

Section III (Optional): PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED

Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

_____

Name of Authorized Person or Entity Relationship Phone #

_____

Name of Authorized Person or Entity Relationship Phone #

Section IV: AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL

Women's Health Services physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Health Care Information that we may possibly disclose on your home, work, or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

_____ (Initial) Yes, I agree to allow Women's Health Services physicians and healthcare staff to leave messages that include Protected Healthcare Information on all three communication devices: home, work and cell phone.

_____ (Initial) I agree to allow Women's Health Services physicians and healthcare staff to leave messages that include Protected Healthcare Information on the following: Please initial next to the applicable communication devices: _____ home number, _____ work number or _____cell number.

_____ (Initial) No, I do not agree to allow Women's Health Services physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

_____

Patient's Signature Date

For WHSMD Internal Use Only

Section V: UNABLE TO OBTAIN NOTICE RECEIPT ACKNOWLEDGEMENT

Option 1: I could not obtain a signed Notice Receipt Acknowledgement from the patient for the following reason:

_____

_____

Option 2: I attempted to obtain a signed Notice Receipt Acknowledgement from the patient on ____/___/___, but was unable for the following reason:

_____

_____

_____

WHSMD Employee Signature Date

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPAA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

HIPAA OMNIBUS Notice of Privacy Practices Effective as of April 1, 2017

Women's Health Services of Maryland, LLC.
1600 Crain Hwy South Ste 106, Glen Burnie, MD 21061
410-768-0262

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, reimbursement for your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes.

We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically. You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature: _____ **Date:**_____

Women's Health Services
OF MARYLAND

Thank you for scheduling your well woman exam today. A "well woman exam" is considered a preventative or wellness visit. This visit will address preventative health only and is not meant to diagnose or treat problems.

If your provider addresses and/or treats other health issues at this visit that are new or chronic in nature instead of scheduling you for a follow up or sick visit, your health insurance company may assess an additional patient liability for those services. Although most insurance plans include benefits for one preventative health visit, some do not. If you have any doubts, please check with your insurance plan.

If you need further explanation about incurring additional fees for services provided during your visit today, please discuss your concerns with your provider.

I acknowledge that I have read this notice prior to being seen and I understand that depending on the issues addressed or treated during today's visit, additional charges may apply.

Patient Signature: _____ Date: _____

Women's Health Service's of Maryland

1600 Crain Hwy South, Suite 106

Glen Burnie, MD 21061

Phone:(410)768-0262

Fax:(410)768-7730

Women's Health Services OF MARYLAND

24 Hour Cancellation and No Show Policy

Your appointments are very important to us, they are reserved especially for you. Please understand that when you forget or cancel appointment without giving enough notice, we miss the opportunity to fill that appointment time and clients on our waiting list miss the opportunity to receive services. We understand thasometimes adjustment is necessary; therefore, we respectfully request at least 12 hours' notice for cancellations. Cancellations without a notice or notices less than 12 hours may result in a charge of ***$25.00***. No shows may be required to pay ***$25.00*** fee.

- Patients with " 3 " no shows or repeat cancellations without 24hrs notice will be discharged from the practice.

Thank you for your cooperation and understanding!!

Patient signature _____ Date_____