Southern Women's Specialists

Pearson and Guepet

7540 Cipriano Court, Suite C
Fairhope, AL 36532
Phone (251) 990-1985, Fax (251) 990-1986

****This information is updated yearly for office purposes****

Patient's
Legal Name: ____________________/____________________/_____/__________/______________
Last First MI Maiden Preferred Name

DOB: ____________________ Age: ____________________ SSN: ____________________

DL #: ____________________State__________ Marital Status ___M___S___W___D

Mailing Address: ____________________ City/State: ____________________ Zip: __________

Primary Phone: (____)____________________ Cell: (____)____________________

Occupation/Employer: ____________________ Phone: (____)____________________

Spouse's Name: ____________________ SSN: ____________________ DOB: ____________

Emergency
Contact: ____________________ Relationship: ______________ Phone: (____)______________
(*If other than spouse)

PLEASE PRESENT YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE FOR PHOTOCOPY

INSURANCE INFORMATION

1st Insurance: ____________________ Contract # ____________________ Group #______________

2nd Insurance: ____________________ Contract # ____________________ Group #______________

*****RESPONSIBLE PARTY INFORMATION*****
THIS IS THE INDIVIDUAL WHO HAS THE INSURANCE, IF OTHER THAN THE PATIENT

1. Name: ____________________ Phone (____)____________________

   DOB: ______________ SSN: ____________________ Relationship to Patient: ______________

2. Name: ____________________ Phone: (____)____________________

   DOB: ______________ SSN: ____________________ Relationship to Patient: ______________

Guarantee of Payment

I, the undersigned, hereby agree to pay all amounts and charges incurred by members of my family for services rendered by our physician(s). I further agree that it is my responsibility to know and understand the provisions and limitations stated in my insurance policy as well as the current list of providers in my contract, and accept full responsibility for all charges not covered by my insurance. Failure to make payment requested is basis for legal action and the undersigned agrees to pay all costs of collection, including a reasonable fee and waives his/her right of exemption under law of the State of Alabama and any other state.

Alignment of Benefits

In consideration of care and services rendered to me by physician(s) during this office visit. I assign the benefits payable under my insurance policies for physicians services to the physician furnishing the services or to their authorized billing agent insofar as necessary to cover their charges. I authorize such physician(s) or their billing agent to submit a claim to my insurance carrier for payment for me and authorize payment to be made directly to said physician(s) billing agent or organization.

Assignment of Claims Against Third Parties

In consideration of care rendered to me by physician(s), I hereby assign to the physician(s) rendering services all claims that I may have against third parties who may be liable for any of my medical expenses, to the extent necessary to cover my expenses for physician(s) care and services. Any funds received by me in connection with such claims against third parties, or settlement of such claims, shall be paid to the said physician(s) to cover my expenses. I hereby authorize payment directly to said physician(s) or the authorized billing agent of any of the above-mentioned funds which are otherwise payable to me but not to exceed the regular reasonable charges for this service.

Medicare Benefits to Physician(s)

I certify that the information given by me in applying for payment under Title XVIIl of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by physician(s). I authorize a holder of medical or other information about me to be released in order to process claim(s) and request payment of my benefits to the physician rendering service.

Authorization to Release Information

I hereby authorize physicians rendering services to release to my insurers, billing and certain medical information including final diagnosis and operative procedure(s) relative to this or related hospital claim(s) and/or office claim(s) for the purpose of determining eligibility for coverage and payment of charges for services rendered in connection with this hospitalization and/or office care. I also give permission for my physician to release my medical information to another physician assisting in my healthcare.

Privacy Notice

I hereby acknowledge receipt of your practice's privacy notice and understand that your Privacy Policy is posted in your patient waiting room.

(Please complete all information IF person financially responsible is someone other than patient

Name: ____________________________________ Address: ____

City: ______________________ State: ________ Zip: ______________ Phone: (____)________________

____ ____

*Signature of Patient Required Date Signature of Financial Guarantor Date

RELEASE OF INFORMATION

Name: ____ Date: _____________

I authorize Southern Women's Specialists Gynecology to contact me in reference to any items that will assist the practice in providing optimal care such as appointment reminders, insurance or billing information and any information pertaining to my clinical care, including lab results. This may include automated calls sent to a home telephone, cell phone (including text messaging), voicemail/answering machines and email.

Email Address: ____

Primary Phone: ______________________________ Cell phone: ___________________________

Preferred Pharmacy: __________________________ Pharmacy Phone: ______________________

With my consent, all financial and/or medical information can be given to the following people:

____

Name Financial Medical Relationship Phone

____

Name Relationship Phone
Financial Medical

____

Name Relationship Phone
Financial Medical

By signing below, I understand that I am allowing Southern Women's Specialists Gynecology's staff to speak to the above identified person(s) in reference to any and all of my Personal Health Information(PHI). I also understand that I can change this list at any time by appearing in person or in writing by sending a request to the office of:

Southern Women's Specialists
7540 Cipriano Court, Suite C
Fairhope, AL 36532

____ Patient

Signature of 14 and older Legal Guardian Signature

Southern Women's Specialists
Pearson and Gucpet

Financial Policy

Thank you for choosing Southern Women's Specialists Gynecology. We want to provide the best care possible to you. **Please understand payment for our services is part of your treatment and care and this statement explains our policies and procedures in that endeavor. Knowledge of your individual insurance plan coverage remains your responsibility, therefore we urge you to check with your insurance company prior to any testing or surgery to be performed.**

Our practice policy requires that prior to any services being rendered, all patients must sign the practice Financial and Termination of Care Policy. We ask that you please present to the office with a form of payment to meet your obligations to your insurance provider and to your healthcare provider. We thank you in advance for taking the time to review these policies. Please feel free to discuss any concerns or questions you may have with our billing staff or our practice manager. We would welcome the opportunity to assist you in your understanding the complexities of health insurance today.

<u>We require the following before we can provide your care and treatment</u>

*Copy of most current insurance card, updated demographic information and driver's license
*Copayment or payment of non-covered services.
*Referral if required by your insurance plan.

PLEASE NOTE: IF YOU ARE UNABLE TO PROVIDE THE ABOVE INFORMATION PRIOR TO YOUR APPOINTMENT, YOU WILL BE ASKED TO RESCHEDULE YOUR APPOINTMENT OR PRESENT AS A CASH PAY PATIENT.

*****WE DO NOT BILL COPAYS*****

<u>Missed or Cancelled Appointment Fees</u>

*As a courtesy to our patients, your appointment will be confirmed by our automated confirmation system several days prior to your appointment. Again, this is a courtesy reminder and there is no guarantee that the reminder system will be able to reach you. It is your responsibility to manage your appointments.
*24-hour notice is required to cancel and reschedule all appointments. Failure to do so will result in a $25.00 NO SHOW fee for established patients and $50.00 for new patients.
*New patient appointments will not be rescheduled after 2 calls to reschedule.
*All balances, including NO SHOW fees are due prior to any further services provided by our practice.

<u>The following Service Charges may apply</u>

*A 3.5% non-cash fee will be applied to all credit and debit card purchases. No fees will be charged on health savings cards or Care Credit charges.
*$40 for all insufficient checks. Your personal check can no longer be accepted if you have an insufficient check processed.
*$10 for FMLA or work related paperwork. This paperwork requires 7 business days to complete.

<u>Laboratory/Hospital Charges</u>

*Gen Path/Bio Reference is the on-site laboratory at our Practice.
*It is the patient's responsibility to assure that their insurance will cover labs drawn from this lab.

*Any service(s) provided by a lab or hospital is a contract between the patient and that facility. Any dispute for charges incurred by the lab or hospital should be handled with that facility and is not the responsibility of this Practice.

Surgery Fees/Contracts

*You will be given an estimate of fees for these services that are based on your plans physician fee schedule IF AVAILABLE. Our surgical assistants and business office will contact you with information regarding deductible and coinsurances due prior to surgery.

Termination of Care Policy

Southern Women's Specialists Gynecology reserve the right to dismiss a patient for the following reasons:

*Failure to pay for services in a timely manner.
*Excessive rescheduling, no shows or tardiness of visits.
*Noncompliance of recommended care.
*Noncompliance with the conduct and service policies.

Conduct/Behavior and Method of Contact Policy

Our office strives to provide an environment of excellence and professionalism in the best possible manner. Therefore, in order to ensure that everyone feels comfortable, we expect all of our valued patients to be mindful of their conduct. Any inappropriate language, loud conversation or disrespectful demeanor towards our staff will not be tolerated.

Please contact our office during business hours if you have questions or concerns about your care. There is always a doctor on call after hours to address EMERGENCIES only. Please refrain from contacting our office via social media including FACEBOOK or LinkedIn. The use of social media is not HIPAA compliant and we will not answer messages left on our FACEBOOK page.

The staff and physician's personal time is very important and we ask that patients do not contact them after hours at their personal residence, personal email, Facebook, other social media, or via their personal telephone numbers.

If you have a medical emergency, please visit your nearest Emergency Room immediately.

By signing below, I acknowledge the practice has provided me with a copy of the Financial and Termination of Care Policy. Furthermore, I agree to comply with the policies and procedures set forth accordingly.

____

Patient Signature

____

Patient's Printed Name

____

Date

NOTIFICATION OF NON-COVERED SERVICES

At Southern Women's Specialists Gynecology we want to provide you with the best care possible. There are services and procedures that your doctor may feel is necessary for the treatment of your condition and maintenance of good health that are not covered by your benefits contract. You are expected to pay for those services in full if your insurance opts not to pay for them.

Please be assured that the doctors will order only the tests and treatments that they feel are necessary for your treatment and care. These services include, but are not limited to the following:

PROCEDURE	COST
Urinalysis	$ 8.00
Pregnancy Test	$ 8.10
Urine Culture	$ 14.00
Hemocult/Fit Test	$ 25.00
Transvaginal Ultrasound	$ 122.00
Abdominal Ultrasound	$ 122.00
Cystoscopy	$ 235.00
Urodynamics Testing	$ 895.00
Hysteroscopy In Office	$ 550.00
PNE Trial(Interstim Trial)	$ 1000.00
Trigger Point Injections	$ 50.00

Please note that laboratory and pathology charges are billed separately by the lab on site, not Southern Women's Specialists Gynecology. Please consult with your insurance provider to verify coverage for lab services. If your insurance provides coverage for these services but applies services to your plan deductible, cost to you may be more based on your plans fee schedule. These charges apply only if your insurance denies coverage.

Thank you for your understanding.

I have read and understand the policy concerning non covered services outlined above.

____

Patient Signature Date

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NOTICE OF PRIVACY PRACTICES

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*.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny *your* request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice. Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact _Wendy Shelton, Privacy Officer, [251 990-1985 7540 CIPRIANO COURT SUITE C. FAIRHOPE, AL 36532]. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights

____ ____________________

Patient or Patient's Personal Representative **Date**

MEDICAL HISTORY FORM

Name______________________________ DOB___________________ Age_____ Today's Date___________

Your PCP/Family Physician____________________________________

Date of your last visit____

Please complete the following. This information will assist us in your evaluation today.

REASON FOR TODAY'S VISIT:

___I need an annual gynecological exam.

___I am having a specific problem. Please describe ____

____

____

List any allergies and reactions to allergies____

____

List current medications, including prescribed medications, vitamins, herbal or diet supplements and other over the counter medications. List dosages and the dates started. Attach a medication list if you have one.

____

____

____

____

Current method of contraception(oral, IUD, tubal, vasectomy,

other)________________________________ DATES OF YOUR LAST

Mammogram_________________Pap Smear________________Bone Density________________

Colonoscopy_________________

PAST MEDICAL PROBLEMS AND DATES OF PROBLEMS(ex: hypertension, diabetes)

____

____

____

PAST SURGERIES AND DATES OF EACH SURGERY____

____

____

____

SOCIAL HISTORY

Do you currently smoke? ____No____Yes How much?________________________________

Did you previously smoke ____No____Yes When did you start?_________________________

How much?________________________________

When did you stop?_________________________

Do you drink alcohol? ____No____Yes How much?________________________________

Did you previously drink? ____No____Yes When did you start?_________________________

How much?________________________________

When did you stop?_________________________

Do you currently use recreational drugs? ____No____Yes Which drug(s)?___________________________
When did you start?_________________________

How much?________________________________

Have you ever used recreational drugs? ____No____Yes Which drug(s)?___________________________
When did you start?_________________________
How much?________________________________

When did you stop?_________________________

FAMILY HISTORY

Breast Cancer Y N Maternal or Paternal Relationship______________Age at diagnosis_________

Ovarian Cancer Y N Maternal or Paternal Relationship______________Age at diagnosis_________

Colon Cancer Y N Maternal or Paternal Relationship______________Age at diagnosis_________

REPRODUCTIVE HISTORY

Number of pregancies____________________

List outcome of each pregnancy, including dates delivered, vaginal or C-section, sex and weight of baby, and any complications with the pregnancy:

1.____
2.____
3.____
4.____
5.____

Date of last menstrual period_______________________________
Are your cycles light, moderate or heavy?______________________________
Are your cycles regular or irregular?___________________________________
Too frequent or too few?___________________
Number of weeks between cycles______________________________________
Do you suffer from painful cycles? _____No_____Yes

REVIEW OF SYSTEMS

Do you currently have any problems related to the following systems?
Please mark YES or NO

Constitutional

Fever	Yes	No
Chills	Yes	No
Weight Loss	Yes	No

Eyes

Glaucoma	Yes	No
Cataracts	Yes	No

Cardiovascular

Chest Pain	Yes	No
Irregular heart beat	Yes	No

Respiratory

Shortness of breath	Yes	No
Wheezing	Yes	No
Cough	Yes	No

Gastrointestinal

Nausea	Yes	No
Vomiting	Yes	No
Abdominal pain	Yes	No
Heartburn	Yes	No
Recent changes in bowel habits	Yes	No

Hemotologic/Lymphatic

Blood Clotting Problems	Yes	No
Swollen Glands	Yes	No

Breasts

Masses	Yes	No
Nipple Discharge	Yes	No

Musculoskeletal

Muscle Pain	Yes	No
Joint Pain	Yes	No

Psychological

Anxiety	Yes	No
Depression	Yes	No

Allergies

Drug Allergies	Yes	No
Seasonal	Yes	No

Genitourinary

Urinary frequency	Yes	No
Urinary loss	Yes	No
Nighttime urination	Yes	No
Painful urination	Yes	No
Vaginal Discharge	Yes	No
Vaginal Dryness	Yes	No
Painful Intercourse	Yes	No
Decreased Libido	Yes	No
Orgasm Difficulties	Yes	No
Vaginal Laxity	Yes	No