HORIZON WOMEN'S HEALTH
OBSTETRICS AND GYNECOLOGY

DATE______________ PATIENT (Print Name) ______________________________ BIRTHDATE____________

ADDRESS ______________________________ apt#________ (city) __________________ (state)______ (zip)________

HOME PHONE__________________________ CELL _________________________ SSN_______________

MARITAL STATUS: _________ SPOUSE _____________________________ DOB _______________

EMAIL: _________________________ RACE_______________ ETHNICITY_______________________

INSURANCE

PRIMARY INSURANCE ___________________________________ EFF DATE__________________

ID#_______________________________________ GROUP#__________________________

SUBSCRIBER NAME____ DOB_______________________

SSN_____________________________________ RELATION TO PT____________________________

SUBSCRIBER EMPLOYER____

BUS ADDRESS____

BUS PHONE___________________________________ OCCUPATION_____________________________

SECONDARY INSURANCE___________________________________ EFF DATE__________________

ID#_______________________________________ GROUP#__________________________

SUBSCRIBER NAME____ DOB_____________________

SSN_____________________________________ RELATION TO PT____________________________

SUBSCRIBER EMPLOYER____

BUS ADDRESS____

BUS PHONE___________________________________ OCCUPATION_____________________________

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME____ RELATIONSHIP__________________

ADDRESS____ PHONE_______________________

IF PATIENT IS A MINOR WE MUST HAVE THE FOLLOWING INFORMATION

(**WE MUST ALSO HAVE A SIGNED MINOR CONSENT FORM ON FILE**)

PARENT OR LEGAL GUARDIAN____

NAME OF PERSON RESPONSIBLE FOR CHARGES ____

DATE OF BIRTH__________________________________ SSN_____________________________

ADDRESS____

HOME PHONE_________________________________ CELL ______________________________

NOTE:
THERE WILL BE A SEPARATE BILL FROM ANY APPLICABLE LABORATORY FOR PAP SMEAR INTERPRETATION, CULTURES, URINALYSIS, PATHOLOGY AND ANY OTHER LABORATORY STUDY; OB PATIENTS MAY BE RELEASED FROM CARE IF SCHEDULED PRENATAL APPOINTMENTS ARE MISSED AS WE WILL BE UNABLE TO PROVIDE ADEQUATE CARE; PRESCRIPTION REFILLS REQUIRE A MINIMUM OF 48 HOURS NOTICE. HAVE YOUR PHARMACY FAX US THE REQUEST. PLEASE UNDERSTAND THAT SOME PRESCRIPTION REFILLS REQUIRE AN OFFICE VISIT.

Patient Signature____ **Date**________________

(Updated 11/10/2017)

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the release of any medical information resulting from or necessary to process any claim for service provided by Horizon Women's Health

I authorize my insurance company to pay Horizon Women's Health directly for my care. I understand I am responsible for any amount not covered by insurance.

SIGNATURE____ DATE_____________

PARENT/RESPONSIBLE PARTY/GUARDIAN
SIGNATURE____ DATE_____________

ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Horizon Women's Health Notice of Privacy Practices_____________(please initial)

CONSENT TO DISCUSS PATIENT INFORMATION

FEDERAL LAW PREVENTS THIS OFFICE FROM DISCUSSING PATIENT INFORMATION WITHOUT EXPRESS WRITTEN CONSENT FROM THE PATIENT. IF YOU WOULD LIKE THIS OFFICE TO BE ABLE TO DISCUSS YOUR MEDICAL CARE (**INCLUDING APPOINTMENT TIMES**) WITH SOMEONE OTHER THAN YOURSELF, PLEASE LIST THE NAMES OF THE INDIVIDUALS AND THEIR RELATIONSHIP BELOW. YOU CAN CHANGE THIS LIST AT ANY TIME.

	NAME	RELATIONSHIP
1		
2		
3		
4		

SIGNATURE____ DATE_____________

HORIZON WOMEN'S HEALTH
PATIENT FINANCIAL POLICY

Welcome to our Practice! Horizon Women's Health is committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

In order to better serve your needs and clarify any questions that you may have regarding your insurance, we have adopted the following financial policy. If you have any questions, please speak with one of the members of our billing office and they will gladly assist you.

1. Office co-pays, deductibles, and co-insurance amounts are collected at the time of service. **SURGERY AND PREGNANCY** co-pays, deductibles, and co-insurance amounts are payable in advance. Cash, credit and debit cards are accepted.
2. We will review your insurance card(s) at each visit. All insurance changes MUST be given to us at the time of service. If your insurance changes, and we are not notified, YOU will be responsible for all charges. We will not bill your insurance for any charges before the change notification.
3. For medical care not covered by your insurance, payment in full is due at the time of service.
4. OB (PREGNANCY) patients without maternity benefits or insurance will be set up on a cash plan to be paid **IN FULL** before the third trimester.
5. If you have insurance that we do not participate with, we will be happy to file the claim on your behalf; however, payment in full is expected at the time of service.
6. If the patient is a minor (18 years or younger), the parent or guardian must sign a Minor Consent Form. The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of service. Pregnant patients under 18 are fully responsible for any charges not covered unless assignment for those charges is transferred to another adult or guardian.
7. There is a $25.00 fee for the completion of any forms (i.e. disability, leave of absences, etc.) which require a physician signature, that are not associated with the reimbursement of a claim. Please allow 7-10 business days for completion of these forms.
8. **Returned check fee** of $30.00 will be charged for any returned checks.
9. Surgeries not cancelled or rescheduled at least seven (7) business days prior to the surgery date will incur $75 charge. ALL in-office procedures (including aesthetic appointments) not cancelled or rescheduled at least three (3) business days will incur $25 charge.
   ****THESE FEES ARE NOT COVERED BY INSURANCE. YOU ARE RESPONSIBLE.****
10. **UNPAID BALANCES** will incur a $30 late fee after 60 days. Accounts 90 days past due will be turned over to our collection agency and will be assessed a collection fee, minimum $30. We will make every effort to notify you that your account is being turned over to our collection agency.

Print Name: ______________________________ Date of Birth: ________________

Signature: ______________________________ Date: ____________________

(Updated 11/10/2017)

We are happy to answer whatever insurance questions you have. However, you must realize that:

a. Your insurance is a contract between you, your employer, and the insurance company. We are often not a party to that contract.
b. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

Our practice is committed to providing the best treatment for our patients, and we charge what is appropriate based on geographic location, physician skill and expertise. You are responsible for payment regardless of any insurance company's arbitrary determination of *usual and customary* rates.

We must emphasize that as a medical care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Our practice firmly believes that a good physician/patient relationship is bases upon understanding and good communication. If you have any questions about the above information, please do not hesitate to speak with someone in our office. We are here to help.

AUTHORIZATION:

I consent to and authorize Horizon Women's Health to treat any condition that I might have and seek treatment for.

In addition, I agree to my financial responsibility to Horizon Women's Health for services rendered. I have read and received the Patient Financial Policy.

2002 Centers for Disease control (CDC) guidelines state every sexually active woman should be screened for vaginal infections, including sexually transmitted diseases, at the time of her annual pap smear. Horizon Women's Health follows these guidelines. If you choose not to abide by these guidelines, please notify the nurse.

Patient Name (please print):____

Patient Signature: ____________________________________ **Date:**____________

Guarantor Name (for patients under 18): ______________________________

Guarantor Signature: _________________________________ **Date:**____________

NOTICE OF PRIVACY PRACTICES

EFFECTIVE: APRIL 14, 2003

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**

If you have any questions about this notice, please contact HWH at 898-7226

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment related health care services. For example, we may disclose health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give you health plan information to such entities so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

PLEASE FILL OUT THE FOLLOWING INFORMATION.
POR FAVOR COMPLETE LA SIGUIENTE INFORMACIÓN.

Name/Nombre:______________________________
Birthdate/Fecha de Nacimiento:____________________

Please confirm which lab we should send your specimens to.
You are responsible for any lab fees as we do not bill for the lab.

Confirme a qué laboratorio debemos enviar sus muestras.
Usted es responsable de cualquier pago de laboratorio, ya que nosotros no estamos encargados de los cargos del laboratorio.

Lab/Laboratorio:______________________________________

Please confirm which pharmacy you would like your prescriptions to be sent to.

Confirme a qué farmacia desea que le envíen sus recetas.

Pharmacy/Farmacia
Name/Nombre:______________________________________
Address/Dirección:____________________________________
City/Ciudad________________State__________Zip________