

EXCEPTIONAL CARE FOR WOMEN

PLEASE FILL OUT COMPLETELY

Date: _____

Usual provider (circle one): Dr. Arendt Dr. Ryan Dr. Boydston Dr. Wagers Dr. Bron Natalie Ballweber, PA-C

Patient's full name: _____ SSN: _____

Street address: _____ Home Phone: (____) _____ leave message?

City: _____ State: _____ Zip: _____ Work Phone: (____) _____ leave message?

Date of birth: _____ Cell Phone: (____) _____ leave message?

Email address: _____ Preferred method of contact: Home Work Cell

Former/maiden name: _____ Marital: S M D W Separated

Preferred Pharmacy: _____ Employer: _____

Primary care provider/referring doctor: _____

Emergency contact: _____ Phone/type: (____) _____ Home Work Cell

Relationship to contact: _____

PERSON RESPONSIBLE FOR INSURANCE

(If different from above)

Policy holder's full legal name: _____ Home: (____) _____

Address: _____ Work: (____) _____

City: _____ State: _____ Zip: _____ Cell: (____) _____

Date of Birth: _____ SSN: _____ Relationship to patient: _____

INSURANCE INFORMATION

Insurance cards MUST be provided at the time of service for billing purposes

Self Pay (no insurance)

Primary insurance name: _____ ID#: _____

Group #: _____ Policy holder's name: _____

Insurance Mailing Address: _____

Secondary insurance name: _____ ID#: _____

Group #: _____ Policy holder's name: _____

Insurance Mailing Address: _____

Over please

*****DEMOGRAPHICS*****

Optional: RACE/ETHNICITY two part Question.

Please answer BOTH questions. (Check as many as apply) OR Decline _____ ("X" if you decline to answer)

Do you consider yourself to be Hispanic or Latino according to the definition?

Yes, I am Hispanic or Latino- A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race

No, I am not Hispanic or Latino

What is your race? (regardless of how you answered the first question)

American Indian or Alaska Native- A person having origins in any of the original peoples of North and South America (including Central America)

Asian -A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam

Black or African American -A person having origins in any of the black racial groups of Africa

Native Hawaiian or Other Pacific Islander- A person having origins in any of the original peoples of Hawaii, Guam, Samoa, other Pacific Islands

White or Caucasian - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa

More than one race

Preferred Language:

English Spanish Other _____

*****FINANCIAL RELEASE*****

I understand that I am responsible for obtaining a referral or proper authorization from my insurance company for each surgery or delivery. It is my responsibility to know which hospital and/or lab my insurance will reimburse for services. Specimens such as Pap smear, tissue biopsy samples, genital cultures, blood samples or urine will be sent to an outside lab contracted through my insurance company. Therefore, an outside charge may be associated with these services. I agree that if the insurance company denies benefits for any reason, I will be responsible for the full amount of the service rendered. I also understand and agree to pay a \$30.00 fee for any returned checks.

I request that payment of authorized insurance/Medicare benefits be made to Exceptional Care for Women (FEIN 26-2216328) for any services rendered. In the event that my account is turned over to a collection agency for non-payment, I agree to pay all reasonable attorney's fees and costs of collection and understand that I am no longer be able to receive care at this office.

I authorize any medical information about me to be released to any or all Health Care Financing Administration, its agents, or my insurance carrier as needed to process and pay my claims or those of my dependant. I have also been made aware of the privacy policies which are in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Patient's signature: _____ Date: _____

Printed name: _____

2017

HIPAA/PATIENT CONTACT CONSENT

2018

By my signature, I acknowledge that I have received a copy of the Notice of Privacy Practices from Exceptional Care for Women.

Please print patient name: _____

Date of Birth: _____

Guardian/Patient signature: _____

In caring for our patients, it may be necessary for Exceptional Care for Women to contact you by phone. When we are not available to speak to you directly, we like to leave messages when possible. In order to protect your privacy, it is ECW's policy to:

- ▶ NOT leave messages with anyone except the patient or legal guardian;
- ▶ NOT leave specific information on an answering machine/voice mail system.
- ▶ UNLESS we have your written permission to do so.

Please review the information below and **consider carefully** whom you choose to have access to your medical information, such as scheduling information about an upcoming procedure, inquiries about your insurance or billing information. Please check the applicable ways for us to reach you/leave a message for you. We are unable to speak to any person unless you list them by name on this document.

CONSENT:

- Home phone or answering machine/voice (detailed message)
- Cell phone or answering machine/voice (detailed message)
- Office phone or office voice mail (detailed message)
- Spouse (detailed message) Spouse's name: _____
- Other person, phone etc. _____

DENIAL:

I _____, wish to be contacted personally and **do not** authorized ECW to leave detailed messages with any other person or via answering machine/voice mail system.

You have the option to update and/or change your preferences of how we contact you at any time by completing a new PATIENT CONTACT CONSENT form or otherwise putting your request in writing and submitting it to Exceptional Care for Women.

Signature (Parent/Guardian)

Date