PATIENT INFORMATION

Name (Last) _____ (First) _____(M.I.) _____

Address: _____

City _____ State _____ Zip _____

Social Security Number: _____

Date of Birth: _____ Age: _____ Home Phone: _____

Work Phone#_____

Cell Phone: _____ Marital Status: _____

Employer:_____

Emergency, Contact:_____Phone#_____

Referring Physician: _____

E-mail: _____ Ethnicity: _____

RESPONSIBLE PARTY

Guarantor's Name: _____

Address: _____

Patient Relation to Guarantor: _____ Guarantor's Employer:_____

Guarantor's Date of Birth: _____(M/F) _____

PRIMARY INSURANCE

Name of Insurance Company: _____

Subscriber's Name: _____Patient Relation to Subscriber: _____

Subscriber's ID# _____ Group # _____

Insurance Address:_____

Insurance Phone # _____ Subscriber's Date of Birth: _____ (M/F) _____

SECONDARY INSURANCE

Name of Insurance Company: _____

Subscriber's Name: _____ Patient Relation to Subscriber: _____

Subscriber's ID# _____ Group # _____

Insurance Address: _____

Insurance Phone # _____Subscriber's Date of Birth _____ (M/F) _____

PHARMACY INFORMATION

Whenever possible, Advanced Care for Women, LLC will electronically transmit your prescription(s) directly to your pharmacy. Please provide us with your preferred pharmacy information in the space below

Pharmacy Name: _____ Phone Number:_____

Pharmacy Address: _____ City/State/Zip _____

PRIMARY CARE PHYSICIAN

Primary Care Physician: _____ Telephone Number: _____

Address: _____ City/State/Zip: _____

CONSENT TO TREATMENT

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments, the administration of any needed anesthetics; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medications; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees may consider medically necessary or advisable.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

I hereby authorize Advanced Care for Women, LLC to release medical information to any healthcare provider or third-party insurance company for the purpose of treatment, payment or operations, which may pertain to my care. I hereby authorize payment directly to Advanced Care for Women, LLC of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by any third party carrier and in accordance with contractual terms and participatory agreements. Further, I acknowledge that I am indebted for past due charges, and I understand that I am financially responsible for those charges also. Should this account become delinquent, I agree to pay a collection fee not to exceed 33 1/3% of the balance then outstanding in addition to any court costs and/or including attorney fees.

MEDICARE PATIENTS: I authorize Advanced Care for Women, LLC to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Advanced Care for Women, LLC.

In accordance with the provisions of Section 32.1-45.1 of the Code of Virginia (whenever any health care provider or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may according to the current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus), the patient whose body fluids were involved in the exposure shall be deemed to have consented for testing for infection with human immunodeficiency virus. If there is an exposure and the patient's test is positive the attending physicians will notify the patient, any person exposed, and the Virginia Health Department and appropriate counseling will be offered. I have reviewed and understand my patient rights and responsibilities. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient's Signature _____ Date:_____

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name :_____ Birthdate: _____

Signature: _____Date :_____

Patient Policy for Missed Appointments

If you know that you will be unable to keep your appointment, please notify us within 24 hours of your scheduled appointment so that we may accommodate other patients that may require our services. This will assist us in meeting the medical needs of the community that may require immediate attention.
You will be charged a $25.00 fee for missed new patient and follow-up appointments when you do not provide a 24-hour notice.
We appreciate your business and look forward to serving you and your medical needs in the future.

Patient Signature: _____ Date ____/____/____

Patient Name (PRINT): _____

Late Arrival Policy

If you arrive greater than 15 minutes late for your scheduled appointment, to cater to patient's schedules, you will be given the option to wait until the next open appointment time, or reschedule your appointment to a more convenient time.

Patient Signature:_____ Date:___/_____/____

Patient Name (PRINT):_____

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Advanced Care for Women, LLC.** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Our Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Privacy Officer.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to the attention Privacy Officer, **Advanced Care for Women, LLC.** If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern. You will not be penalized or otherwise retaliated against for filing a complaint.