GENESIS WOMEN'S CENTER, P.A

800 Medical Court East, Inverness, FL 34452 – Telephone 352-726-7667

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PATIENT HISTORY

Name:______________________________ Date:______________

Address:______________________________ E-Mail______________

City:______________ State:__________ Zip:__________ SS#:______________

Home#: ______________ Cell:______________ Work:______________

DOB:__________ Age:________ Race:__________ Ethnicity:__________ Language:__________

Occupation:______________ Employer:______________________________

Address:______________________________ Phone:______________

City:______________ State:__________ Zip:__________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Please give the following information about your husband/partner:

Name:______________ SS#:______________ DOB:______________

Occupation:______________ Employer:______________________________

Address:______________________________ Phone:______________

City:______________ State:______________ Zip:______________

In case of an emergency contact:______________________________

Phone:______________ Relationship:______________________________

Family Physician:______________________________ Phone:______________

Dentist: ______________________________ Phone:______________

Preferred Pharmacy:______________________________ Phone:______________

How did you hear about us?______________________________

Who is responsible for payment?______________________________ Phone:______________

I will pay today by: ☐ Cash ☐ Check ☐ Credit Card

To our patients:
We ask for your attention in regards to future appointments. The volume of patients in need of care is high. In order to meet these needs, while also working toward more open access for appointment scheduling, we ask that you strive to give a minimum of a 24 hour notice for cancellations and reschedules. In an effort to improve access for all patients that show a trend in cancellations, no-show appointments, and/or reschedules with a notification after the start time of the appointment may be considered for dismissal from the practice. Initials: ______________

I understand and agree that (regardless of insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I certify the information contained on this form is true and correct to the best of my knowledge. I will notify Genesis Woman's Center, P.A. of any changes in my health status or the above information.

Signature:______________________________ **Date**:______________

Parent Signature (if minor)______________________________ **Date**:______________

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Patient Name____Date of Birth____________________________

PATIENT FINANCIAL AGREEMENT

1. _______________(Patient or Guardian Initials)

   Financial Agreement.
   - I acknowledge, that as a courtesy, GENESIS WOMEN'S CENTER may bill my insurance company for services provided to me.
   - I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by the insurance.
   - I understand that there is a fee for returned checks.

2. _______________(Patient or Guardian Initials)

   Third Party Collection. I acknowledge that GENESIS WOMEN'S CENTER may utilize services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account and billing servicing.

3. _______________(Patient or Guardian Initials)

   Assignment of Benefits. I hereby assign to GENESIS WOMEN'S CENTER any insurance or other third-party benefits available for health care services provided to me. I understand GENESIS WOMEN'S CENTER has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to GENESIS WOMEN'S CENTER, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _______________(Patient or Guardian Initials)

   Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to GENESIS WOMEN'S CENTER by the Medicare or Medicaid program.

5. _______________(Patient or Guardian Initials)

   Consent to Telephone Calls for Financial Communications. I agree that, in order for GENESIS WOMEN'S CENTER, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that GENESIS WOMEN'S CENTER or EBO Servicer and collections agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or GENESIS WOMEN'S CENTER or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _______________(Patient or Guardian Initials)

   A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X____ Date_________________________

If you are not the Patient, please identify your relationship to the Patient.

(**Circle or mark relationship(s) from list below):**

Spouse	**Guarantor**
Parent	**Healthcare Power of Attorney**
Legal Guardian	**Other (Please specify)** ____

GENESIS WOMEN'S CENTER

Patient HIPAA Acknowledgment and Consent Form

LOCATION NAME			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practices

______(**Initials Patient/Representative**) I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.
Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

Updated: October 1, 2018 v7 replacing 012018, 122016, 042216, 102815, 061215, 112113

A photocopy of this consent shall be considered as valid as the original.

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Patient HIPAA Acknowledgment and Consent Form

LOCATION NAME			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc.)	Date

Practice: OPTIONAL ON FORM – REMOVE THIS Prescription Order Pick Up Section ONLY if NA to your practice/clinic

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** __________ (**Initials** Patient/Representative) to designate the following individual to pick up a prescription order on my behalf:

Name	Relationship to Patient

- ***I do not want*** __________ (**Initials** Patient/ Representative**)** to designate anyone to pick-up my prescription order.

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