THE WOMEN'S HEALTHCARE GROUP
Information & Registration

Patient ______ LAST ______ FIRST ______ MI

Birthdate ______/______/______ MONTH DAY YEAR

Address ______ STREET/PO BOX/RURAL ROUTE

______ CITY ______ STATE ______ ZIP

SSN ______-______-______

Home Phone ( )______

Mobile/Pager ( )______

Email Address ______

Work Phone ( )______

Employer ______

Employer's Address ______

Occupation ______

Preferred Method of Contact (Please Circle) Home Work Mobile /Pager

Primary Care Physician ______

Office Phone ( )______

Marital Status (Please Circle): Single Married Divorced Widow

Spouse/Partner: ______

SSN ______-______-______

Birthdate ______/______/______

Spouse/Partner's Employer ______

Work Phone ______

Employer's Address ______ STREET ______ CITY ______ STATE ______ ZIP

(PERSON RESPONSBILE FOR FINANCIAL STATEMENT (IF DIFFERENT THAN PATIENT)

Guardian ______

Relationship ______

Address ______

Home Phone ( )______

Employer ______

Work Phone ( )______

Employer's Address ______ STREET ______ CITY ______ STATE ______ ZIP

Primary Insurance Plan ______

Subscriber Name ______

Birthdate ______/______/______ MONTH DAY YEAR

Secondary Insurance Plan ______

Subscriber Name ______

Birthdate ______/______/______ MONTH DAY YEAR

Third Insurance Plan ______

Subscriber Name ______

Birthdate ______/______/______ MONTH DAY YEAR

Emergency Contact ______

Home Phone ( )______

Relationship ______

Work Phone ( )______

PLEASE LIST ONE RELATIVE NOT LIVING WITH YOU

Name ______

Relationship ______

Address ______

Home Phone ( )______

Work Phone ( )______

How were you referred to our practice? ☐ Physician ______ ☐ Friend ______

☐ Insurance ☐ WHCG Website ☐ Internet ☐ Yellow Pages ☐ Other Advertising ______

The Women's Healthcare Group
Policies, Procedures and Authorization Requirements

The healthcare providers and staff of The Women's Healthcare Group (**WHCG**) strive to offer comprehensive, quality care to all of our patients. We feel that it is appropriate to inform our patients in advance of the policies, procedures, and authorizations required at WHCG that may ultimately affect their care. **Obviously, not all the policies, procedures or authorizations may apply to you, however please read each one carefully and initial at the bottom of each page. PLEASE SIGN AND DATE AT THE END OF THE FORM.** If you are a patient under the age of 18, your responsible party must also read & sign this form.

Cash Accounts
Patients without proof of insurance are responsible, at the time of service, for all expenses incurred during their visit. WHCG accepts cash, checks, money orders, MasterCard, Visa, Discover & American Express credit cards.

Insurance Co-pays
Insurance co-pays are due at the time patients check in for appointment. If patient does not have their co-pay, they will be asked to reschedule their appointment. WHCG accepts cash, checks, money order, Visa, MasterCard, Discover & American Express.

HMO's, Referrals, Pre-Certification & Pre-authorizations
If patient is a member of an HMO insurance plan, their primary care physician (PCP) is contractually bound to direct their health care & is the only physician that can approve referrals. Patients may not receive services from another physician, hospital, or emergency clinic without permission from their PCP. Insurance plans will not allow a PCP to backdate a referral. Patients must request referrals from their PCP in ample time (recommended time is 5 to 10 workings days) to allow PCP's office to approve & forward the referral to WHCG. (In many cases PCP prefer you to pick up the referral & bring it with you to your appointment. Please verify that your referral has been forwarded to WHCG prior to your appointment). As a courtesy to patients, WHCG will often be able to do pre-certifications or pre-authorizations required by insurance. However, many plans require the patient to notify them of scheduled surgeries, hospital admissions, or non-routine care. In the event a surgery, hospital admission, or non-routine care is planned at any facility, the patient must notify their insurance company immediately. Failure to notify your insurance company may result in denial of payment & you will be responsible for payment for those services.

Non-Covered Services
Non-covered services must to be paid at the time of service. Examples of non-covered services include well-woman exams, contraceptive counseling, non-diagnostic ultrasounds & treatment for infertility. The patient should understand that they are responsible for checking benefits with their insurance carrier before their appointment.

Laboratory Testing
Your care at WHCG may include laboratory testing. Tests performed & billed by WHCG include but are not limited to; wet smears, urine pregnancy tests, urinalysis, hemoccults, pH testing, PAP smear, Pathology [Tissue], HPV DNA, GC & Chlamydia. If your insurance plan requires you to have laboratory testing performed by another lab and/or you are having tests performed other than those listed above you will receive a separate billing statement for those services from the designed laboratory. If your insurance plan requires the use of a specific laboratory, you must inform the nurse or the lab tech immediately. WHCG will not be responsible for specimens sent to the wrong laboratory. Patients must understand that there are many lab tests/screenings that WHCG healthcare providers may recommend to be performed in order to provide exceptional care. Some recommended tests/screenings may not be covered by your insurance plan. Healthcare providers have no knowledge of your insurance coverage and there are no guarantees that any recommended test ordered will be covered by your insurance. WHCG and/or an outside laboratory will submit charges for tests performed but you as the patient are ultimately responsible for any fees that are denied by your insurance company. As an informed consumer & active participant in your healthcare, you must make sure that you understand exactly what tests are being ordered by your healthcare provider before permitting the tests being performed.

Returned Check Fees
If WHCG receives a returned check written by a patient or on their behalf, the patient will be charged a returned check fee of $30.00 & will be required to pay cash or use a credit card for any future payments. Failure to repay the returned check & the returned check fee may result in collection proceedings or dismissal as a patient from WHCG.

Account Interest
The patient acknowledges that account balances must be paid within 30 days of receiving a statement reflecting any patient due balance. Account interest will be calculated each month on the amount of the unpaid balance (referred to as Previous Balance) after deducting payments or adjustments & before adding new services. After 30 days patients will be charged a monthly finance charge until the balance is paid in full.

 Initials__________________

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Collection Process
Patient balances that remain unpaid after 90 days will be subject to in house review. If at that time payment arrangements have not been established, the patient will receive a letter from WHCG notifying them that they must pay their balance in full or their account will be forwarded to an outside collection agency & they will be subject to an additional processing fee equal to thirty percent (30%) of their current balance. Patients will NOT be allowed to schedule any further appointments, receive any medication refills, or seek any medical advice of any kind from WHCG until the collection balance is paid in full. In the event their account is sent to an outside collection agency, the patient understands that they will be obligated to pay for any reasonable attorney fees & court costs should the collection proceedings advance to litigation.

Missed Appointments
WHCG may, but is not required to, call the patient to confirm their upcoming appointment date & time. The patient must understand that this is a courtesy & that they are ultimately responsible to keep their office appointment. Patient acknowledges that WHCG may charge a $50.00 missed appointment fee for appointments missed & not changed or cancelled within 24 hours prior to their scheduled appointment.

Phone Calls
WHCG's normal business hours are 8:30am to 5:00pm, Monday through Friday. WHCG is closed holidays & weekends. In the event of an emergency the patient should call 911 or go to their nearest emergency room. We ask patients to call their pharmacy directly during the day for prescription refills for prompt service. The pharmacy will then call our office for renewals if necessary. WHCG will not refill prescriptions after our phone nurse hours of 8:30am to 4:30pm on weekdays. Phone calls received after normal business hours by our healthcare providers that are on call may be subject to a charge. In addition, phone calls made to the patient by our healthcare providers or nurses in order to review test results, counsel or prescribe new medications may be subject to a charge. WHCG may submit a charge to your insurance company for services provided over the phone, however, most insurance companies will not cover this service & the patient will be responsible. These charges do not apply to current obstetrical patients or post-operative patients.

Disability, Insurance or Employment Forms
WHCG will prepare necessary forms supplied by the patient that are required by insurance companies or employers. These forms are often quite detailed & lengthy & therefore cannot be completed quickly. WHCG requests that the patient leave the form at our office for completion with all information that the patient can provide all ready filled in. WHCG staff will then complete the form within ten (10) working days. WHCG will charge a fee for each form (to obtain current fee information please contact our FMLA desk). Payment is required before the forms are released.

Medical Records Releases
WHCG will only release medical records when a valid, HIPAA compliant authorization or a court-ordered subpoena is received. Due to increasing costs of office supplies, equipment & postage, WHCG will assess appropriate fees for the copying & mailing of medical records. Please contact the WHCG Medical Records department for further information.

Discharge of a Patient
WHCG has the right to terminate a patient from our practice at anytime for various reasons, including but not limited to, failure to abide by WHCG financial policies, non-compliance with recommended treatment, drug-seeking activity, & abuse, both verbal & physical, of WHCG providers & staff. If this occurs, the patient's medical records will be released to a physician or healthcare facility of the patient's choice only after an appropriately signed authorization is received by WHCG. Once discharged from WHCG, the patient will not be allowed to return as a patient of WHCG in the future.

Final Costs of Services
Patient may inquire about costs of services for office, laboratory, surgical or obstetrical procedures. WHCG representatives can only estimate potential costs & cannot guarantee any final costs until all procedures have been performed & documentation has been reviewed by WHCG coders & billers. After review of all procedures performed, the patient may receive a statement for additional expenses.

 Initials________________________

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WHCG Insurance Policy
WHCG participates with many health insurance carriers & it is the patient's responsibility to choose a healthcare provider that participates with their insurance plan. It is the patient's responsibility to contact their insurance carrier for a list of participating healthcare providers. If the patient chooses to have a WHCG healthcare provider treat them outside of their insurance network, they will be responsible for all charges denied or reduced by their insurance plan. A current insurance identification card is required at each visit. **If a patient is unable to provide an identification card they will be required to pay for their treatment AT THE TIME OF SERVICE.** The patient is also responsible for informing WHCG if their insurance policy has changed. In the event that claims are denied for timely filing & a new insurance card was not provided by the patient, the patient will then be responsible for those charges. **An insurance policy is a contract between the patient & their insurance company.** The patient is ultimately responsible for all charges incurred at WHCG. It is the patient's responsibility to know the benefits & provisions of their insurance policy. If the patient has any questions or concerns regarding the benefits of their policy, they should contact their insurance company directly.

As a patient of The Women's Healthcare Group, I authorize WHCG to submit a claim & to furnish complete information to my insurance carrier for all services rendered to me by my healthcare provider & authorize & direct my insurance carrier to issue payment on my behalf to The Women's Healthcare Group.

Authorization for Treatment
While I am here, I permit the healthcare providers, WHCG staff & all other persons caring for me to treat me in ways they judge beneficial to me. I understand the attending healthcare provider will explain to me the nature of my condition & his/her recommended treatment & any associated risk involved. I also understand that he/she will explain many possible ways this condition may be treated. I further understand that this care may include diagnostic testing, laboratory testing, examinations & medical and/or surgical treatment. I further understand that no guarantees can or will be made regarding the outcome of this care.

Medicare Lifetime Consent (applies only to patients presenting valid Medicare identification cards)
I certify that the information given by me in applying under Title XVII of the Social Security Act is correct. I authorize the provider of service to submit claims for such service to Medicare & further authorize any holder of medical and/or other information about me to release it to the Social Security Administration, it's intermediaries or carriers any information needed to process this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to The Women's Healthcare Group.

Treatment of Minors
I understand that while and I am under the age of 18 my parent/guardian may be responsible for patient due balances, but that I have been informed that once I turn 18 that I will be the responsible party of my account. WHCG acknowledges that Parent/Guardian may make payments on patient accounts on behalf of the patient.

I HAVE READ & UNDERSTAND THE POLICIES, PROCEDURES & AUTHORIZATION REQUIREMENTS OF THE WOMEN'S HEALTHCARE GROUP.

Please print patient name____ Date of Birth________________

Patient Signature____ Date________________

If patient is less than 18 years of age:

Please print responsible party name____

Responsible Party Signature________________________________ Date________________

Relationship to Patient____

Authorization for Use and Disclosure of Protected Health Information

Other than the entities discussed in the WHCG Notice of Privacy Policy I would like to authorize the following person(s) with the ability to discuss my medical care or treatment & financial responsibilities;

Name: ______________________ **DOB:** __________ **Phone #** ______________

Relationship: ☐ Spouse ☐ Partner ☐ Parent ☐ Guardian ☐ Dependent ☐ Other: ______________

Name: ______________________ **DOB:** __________ **Phone #** ______________

Relationship: ☐ Spouse ☐ Partner ☐ Parent ☐ Guardian ☐ Dependent ☐ Other: ______________

Name: ______________________ **DOB:** __________ **Phone #** ______________

Relationship: ☐ Spouse ☐ Partner ☐ Parent ☐ Guardian ☐ Dependent ☐ Other: ______________

Name: ______________________ **DOB:** __________ **Phone #** ______________

Relationship: ☐ Spouse ☐ Partner ☐ Parent ☐ Guardian ☐ Dependent ☐ Other: ______________

Name: ______________________ **DOB:** __________ **Phone #** ______________

Relationship: ☐ Spouse ☐ Partner ☐ Parent ☐ Guardian ☐ Dependent ☐ Other: ______________

I understand that WHCG will not disclose any information to anyone other than myself unless I have listed them above. This includes but is not limited too my medical care or treatment, medical billing statements, prescriptions, lab results, etc.

I understand that if at any time I want to revoke specific persons from this authorization that I may do so by completing a new authorization and/or send a written notice to WHCG with your request to revoke authorization. My written revocation must be submitted to the privacy officer at:

The Women's Healthcare Group
Attn: HIPAA Privacy Officer
10550 Quivira Road, Suite 410
Overland Park, KS 66215

I understand when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Printed Patient Name: ______________________ DOB: __________ Date: ______________

Patient Signature: ____

Revised 09202013 JLT

Effective Date: September 17, 2013

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 please contact a HIPPA Compliance Committee Member at (913)541-0990.

OUR RESPONSIBILITIES

- **WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY & SECURITY OF YOU PROTECTED HEALTH INFORMATION (PHI).**
- **WE WILL LET YOU KNOW PROMPTLY IF A BREACH OCCURS THAT MAY HAVE COMPROMISED THE PRIVACY OR SECURITY OF YOUR INFORMATION.**
- **WE MUST FOLLOW THE DUTIES & PRIVACY PRACTICES DESCRIBED IN THIS NOTICE & GIVE YOU A COPY OF IT.**
- **WE WILL NOT USE OR SHARE YOUR INFORMATION OTHER THAN AS DESCRIBED HERE UNLESS YOU TELL US WE CAN IN WRITING. IF YOU TELL US WE CAN, YOU MAY CHANGE YOUR MIND AT ANY TIME. LET US KNOW IN WRITING IF YOU CHANGE YOUR MIND.**

YOU HAVE THE RIGHT TO:

Get a copy of your paper or electronic medical record.

- You can ask to see or get an electronic or paper copy of your medical records & other health information we have about you.
- To obtain a copy of your medical record, you must contact our office request & complete a medical record release form.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost based fee.

Correct your paper or electronic medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- To request a correction, you must contact our medical records representative & request a Chart Amendment Form.
- We may say "No" to your request, but we'll tell you why in writing within 60 days.

Request Confidential communication.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- To request confidential communication, please complete the special instructions area of the PHI Restriction Form. Your request must specify how or where you wish to be contacted.
- We will say "Yes" to all reasonable requests.

Ask us to limit the information we share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, & we may say "No" if it would affect your care.
- If you pay for a service or healthcare item out-of-pocket in full, you can as us not to share that information for the purpose of payment or our options with your health insurer. We will say "Yes" unless a law requires us to share that information.

Get a list of those with whom we've shared your information.

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we share it with, & why.
- We will include all the disclosures except those about treatment, payment & health care operations, & certain other disclosures (such as any you asked us to make).
- We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- To request an accounting of disclosures, make your request in writing, to: **The Women's Healthcare Group, 10550 Quivira Road, Suite 410, Overland Park, Kansas 66215**

Get a copy of this privacy notice.

- You can ask for a paper copy of this notice any time, even if you have agreed to receive the notice electronically. We will provide you a paper copy promptly.

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights & make choices about your health information.
- We will make sure the person has this authority & can act for you before we take any action.

File a complaint if you believe your privacy rights have been violated.

- If you believe your privacy rights have been violated, you may file a complaint with our office or with the US Department of Health & Human Services.
- To file a complaint with our office, contact our office for a HIPAA Complaint Form. You will not be penalized for filing a complaint.

- To file a complaint with US Department of Health & Human Services, contact their office at 200 Independence Avenue SW, Washington, DC 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaint/.

YOU HAVE SOME CHOICES IN THE WAY THAT WE USE AND SHARE INFORMATION AS WE:

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, & we will follow your instructions.

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.

If you are unable to tell us your preference, for example if you are unconscious, we may go ahead & share your information if we believe it is in your best interest. We may also share information when needed to lessen a serious & imminent threat to health or safety.

In the below described instances we will never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Psychotherapy Notes

WE MAY USE AND SHARE YOUR INFORMATION AS WE:

Medical Treatment

- We can use your health information & share it with other professionals who are treating you
- *Example: A doctor treating you for an injury ask another doctor about your overall health condition*

Run our organization

- We can use & share your health information to run our practice, improve your care, & contact you when necessary
- *Example: We use health information about you to manage your treatment & services.*

Bill for your services

- We can use & share your health information to bill & get payment from health plans or other entities.
- Example: We give information about you to your health plan so it will pay for your services.

We are allowed or required to share your information in other ways – usually in ways that contribute to public good, such as public health & research. We have to meet many conditions in the law before we can share your information for these purposes. For more info see: www.hhs.gov/ocr/privacy/hipaa/undertanding/consumers/index.html.

Help with public health & safety issues. We can share health information about you for certain situations such as:

- Preventing Disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research

Comply with the law

- We will share information about you if state or federal laws require it, including with the Dept of HHS if it wants to see that we're complying with federal privacy law.

Respond to organ & tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address worker's compensation, law enforcement, & other government requests

- We can use or share health information about you for worker's compensation claims.
- We can use or share health information about you for law enforcement purposes or with a law enforcement officer.
- We can use or share health information about you with health oversight agencies for activities authorized by law.
- We can use or share health information about you for special government functions such as military, national security, & presidential protective services.

Respond to lawsuits & legal actions

- We can share health information about you in response to a court or administrative order, or in a response to a subpoena.

CHANGES TO TERMS OF THIS NOTICE

We can change the terms of this notice, & the changes will apply to all information we have about you. The new notice will be available upon request, on our website, & we will mail a copy to you.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICE

I, ______________________________, acknowledge that I have received a copy of WHCG Notice of Privacy Practice or I choose to obtain an electronic copy via **www.whcg.org** website.

I understand that this notice explains ways in which WHCG may or may not disclose my personal health information [PHI].

I understand that I may have a medical power of attorney or a legal guardian that may act on my behalf if I so choose.

I understand that I may file a complaint if I believe my privacy rights have been violated.

I understand that WHCG's Notice of Privacy Practice may change at any time and that I can request a new copy by contacting our office.

Printed Patient Name ______________________________ DOB ________________

Patient Signature ______________________________ Date ________________

If patient is less than 18 years of age:

Please print responsible party name____

Responsible Party Signature______________________________________Date______________________

Relationship to Patient____

Revised 5/11/2016 DLC