PERSONALIZED WOMEN'S HEALTHCARE, P.A.
AUTHORIZATION OF USE/DISCLOSURE OF PROTECTED INFORMATION

Appointment Reminders: Typically, appointment reminders are sent by mail in a sealed envelope, or a brief non-specific message may be left on your answering machine.

How would you prefer to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for services provided by Personalized Women's Healthcare, P.A. (Check all that apply)

Regular mail______Appointment cards______phone/voice mail_______Fax_______

Cell #_________________Work#___________________Fax#____________________

OK TO LEAVE VOICE MESSAGE- (CIRCLE ONE) **YES** OR **NO**

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochure and/or consent will require your specific 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 will not affect or undo any disclosure prior to your notification date. You have the right to request restrictions on use and disclosure of your health information. **Please list any restrictions below:**

____

____

Persons Authorized to Receive Information:

____
Name of person/relation/organization/phone#

____
Name of person/relation/organization/phone#

____
Print Patient Name

____
Signature of Patient/Date signed

____
Patient Representative Signature/relationship to patient

PERSONALIZED WOMEN'S HEALTHCARE
PATIENT REGISTRATION

Patient Information

Patient Name:_______________ Date of Birth:_______________

Address:_______________City_______________State_______________Zip Code_______________

___ Single ___Married ____ Divorced ___Widowed Social Security #:_______________

Home Phone:_______________ Cell Phone:_______________ Work Phone:_______________

Email Address:_______________ Race:_______________

Employer:_______________Occupation:_______________
Primary Care Physician:_______________ Phone#:_______________
How were you referred to our Practice: _______________
Who is responsible for your medical expenses:_______________

Parent, Spouse, Guardian or Partner Information

Name:_______________ Date of Birth:_______________ Relationship:_______________
Address:_______________City:_______________State:_______________Zip Code:_______________
Home Phone:_______________ Cell Phone:_______________ Work _______________
Phone:_______________Email:_______________
Employer:_______________Occupation:_______________

INSURANCE COMPANY

Primary Insurance Name:_______________ID#_______________Group#_______________
Subscriber Name:_______________ Date of Birth:_______________ Effective Date:_______________
Secondary Insurance Name:_______________ID#_______________Group#_______________
Subscriber Name:_______________ Date of Birth:_______________ Effective Date:_______________
Emergency Contact
Name:_______________ Relation to You:_______________ Phone#:_______________

Authorization for Release of Information
Assignment of Insurance Benefits

I hereby authorize release of information to _______________Insurance Company and assignment of insurance benefits to Personalized Women's Healthcare, Dr. Berry Fleming and Dr. Eric Jacoby, this information may be necessary for the completion of my medical claims. I understand I am financially responsible for all charges not covered by my insurance company.

_______________Date:_______________
Patient or Guarantors Signature

_______________Date:_______________
Witness

Personalized Women's Healthcare

Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with our Practice Manager.

How May I Pay?
We accept payment by cash, check, VISA, Mastercard, and American Express.

What Is My Financial Responsibility for Services?
Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services

If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%-20% coverage."	Patient is responsible for 20% of all office visits, x-ray, injection, and other charges at the time of service. Call your insurance company ahead of time to determine deductibles and coinsurance.	File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	<u>If the services you receive are covered by the plan</u>: All applicable co pays and deductibles are requested at the time of the office visit. <u>If the services you receive are not covered by the plan</u>: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine co pays, deductibles, and non-covered services for you. File an insurance claim on your behalf.
Insurance company with which we are <u>not contracted</u>.	Payment in full for office visits, x-ray, injections, and other charges at the time of service.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out Of Network PPO	Payment is the patient's responsibility—deductible, co pay, non-covered services—at the time of the service.	Call your insurance company ahead of time to determine out of network benefits, co pays, deductibles, and non-covered services. File an insurance claim on your behalf.
Medicare	If you have Regular Medicare, and have not met your deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the service. I<u>f you have Regular Medicare as primary, and also have secondary insurance or Medigap</u>: No payment is necessary at the time of the visit. <u>If you have Regular Medicare as primary, but no secondary insurance</u>: Payment of your 20% co pay is requested at the time of the service.	File the claim on your behalf, as well as any claims to your secondary insurance.
Medicare HMO	All applicable co pays and deductibles at the time of the office visit.	File the claim on your behalf, as well as any claims to your secondary insurance.

If You Have...	You Are Responsible For...	Our Staff Will...
COBRA	If at any time during your care, your insurance benefits are considered COBRA, we must be notified immediately. You must provide proof of coverage. You will be responsible for payment in full at time of service if we can not verify coverage.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Contracted Lab	It is your responsibility to know the contracted lab of your insurance policy.	We will do our best to keep you within your network.
Request for Medical Records	All medical records are copied by outside copy service Photo Stat each Wednesday. We must have a signed authorization to release all medical records. Please allow up to 30 days for this process.	If you are being sent to another physician by your physician, we will fax medical records upon making an appointment
Returned Checks	We will no longer be able to accept checks on your behalf. There will be a $35.00 check return fee and balance is due plus check fee upon receipt.	We will gladly accept cashier's check, money border or credit card for all future visits.
No Insurance	Payment in full at the time of the visit.	Please ask to speak with our staff if you need to make financial arrangements.
Forms to be completed	Payment in full prior to form completion.	Short term Disability-$25.00 Long Term Disability-$35.00 FMLA-$50.00
Missed Appointments	The 2nd time a patient does not show for their appointment, or cancels without a 24 hour notice a fee of $25.00 will be assessed. Insurance will not pay for this and you are responsible for the No Show Fee.	Patients with 3 or more missed appointment's, may be asked to transfer their care.
Divorce or Separation	The party responsible prior to the divorce or separation remains responsible for the account. If divorce decree requires other parent all or part of fees paid, authorizing parent will be responsible and will have to seek payment from the other.	We will collect all fees from the authorizing parent.
Co-Signature	In special circumstances, a co-signature may be required.	We will discuss this policy with you.

Surgery/OB Patients

If your physician recommends surgery, you will be contacted by his Surgery Coordinator. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it. The Surgery Coordinator will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be presented by the Surgery Coordinator. You, the patient, are responsible for knowing your insurance benefit coverage.

PERSONALIZED WOMEN'S HEALTHCARE
FINANICAL OFFICE POLICY

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility and are due at time of service.

I authorize my insurance benefits be paid directly to Personalized Women's Healthcare.

I authorize Personalized Women's Healthcare to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

________	________________________	___________________
Date	Signature of Patient/Guardian	Printed Name
________	________________________	___________________
Date	Witness	Printed Name

Personalized Women's Healthcare, P.A.

Berry A. Fleming, MD

Eric B. Jacoby, MD

Sue Thomas, RN-P

Name ______________________ Date __________ Age __________

Drug Allergies ______________________ Medications ______________________

Referred by: Physician ______________________ Friend ______________________

Who is your Primary Care Physician? ______________________

What concerns bring you to the office? ______________________

Past Medical History		**Surgery**	
Diabetes	______	Breast	______
Heart Disease	______	Tonsils	______
Lung Disease	______	Hysterectomy	______
Hypertension	______	Orthopedic	______
Liver	______	Appendix	______
Kidney	______	Gallbladder	______
Neurologic	______	Pregnancy #	______
Blood vessels	______	Vaginal deliveries #	______
Other	______	C-Sections # ______	Miscarriage/Abortions ______

Family History	Relative		Relative
Breast Cancer	______	Bleeding/clotting disorder	______
Female Cancer	______	Diabetes	______
Birth Defects	______	Other	______

Lifestyle Alcohol yes no Cigarettes yes no Drug use yes no Exercise yes no

Last menstrual period ______ Last Pap smear ______ Mammogram ______

Last cholesterol test ______ Colonoscopy ______ Osteoporosis test ______

Type of birth control ______________ Need information about birth control? yes no

ANNUAL HEALTH UPDATE

Personalized Women's Healthcare, PA

Name ______________________________ Height __________

To assist us in caring for you, please answer the following questions.

1. Has there been any change in your periods? ______________________________

2. Are you using any type of birth control? Yes No

   Type ______________________________

3. Have you had any illnesses since you were here last? Yes No

   Type ______________________________

4. Have you had any surgeries since you were here last? Yes No

   Type ______________________________

5. Have you seen other doctors? Yes No Whom ______________________________

6. What Medications are you taking? ______________________________

   ____

7. Cigarettes ________ per day Alcohol ____________ Drug Use ____________

8. When have you last had the following tests:

   Mammogram ________ Cholesterol ________ Colonoscopy ________ Bone density ________

9. When was your last menstrual period? ______________________________ N/A

10. Do you exercise? Yes No Type ______________________________

11. Have any new diseases occurred in your family? Yes No Type ______________

    ____

12. Do you need any prescriptions refilled today? Yes No Type ______________

    ____

13. Pharmacy name, location, or number. ______________________________

    ____

Dear Patient:

At Personalized Women's Healthcare we pride ourselves on offering our patients the most advanced preventative care available. We now offer our patients the FDA-approved high-risk digene HPV test. This test is a highly sensitive viral test used in conjunction with a Pap test for cervical cancer screening in women aged 30 and older. Persistent infection with high-risk human papillomavirus (HPV) is the primary cause of cervical cancer. A few important things to know about HPV and cervical cancer screening:

- Most women (80%) will have HPV at some point during their lives but very few will develop cervical cancer
- Fortunately, in most people, the body's immune system suppresses the HPV virus before it causes problems. It is only when the infection persists that it can cause cells to become abnormal. By catching persistent infections while they are still relatively early in their development, abnormal cells can be detected and removed before they become cancerous. That is why periodic testing for HPV is so important.
- The Pap test looks for abnormal cell changes on the cervix that occur as a result of a persistent high-risk HPV infection. The HPV test looks for the presence of HPV DNA.
- When used together, these tests can show with nearly 100% certainty that you do not have cervical disease. Women who test negative for high-risk HPV, and have a normal Pap test, have virtually no risk of developing cervical cancer before their next scheduled visit.
- Knowing your HPV status helps you and your provider determine how often you should be screened. Early detection of pre-cancerous cell changes is the key to preventing cervical cancer.
- Your HPV status is not a reliable indicator of you or your partner's sexual behavior. HPV can lie dormant in cervical cells for many years before becoming an active infection. There is no way to know when, where, and from whom HPV was acquired, and because HPV is so easily transmitted, anyone who has ever been sexually active is at risk.

Most all insurance companies cover the high-risk HPV test when used with a Pap test for cervical cancer screening of women 30 or older. In fact, the State of Texas requires insurance companies to cover this test as primary screening for women in this age group. However, the individual benefits you or your employer purchased may or may not cover the test. We will exhaust all efforts in assuring that your test will be covered.

☐ I have read the above information and **AGREE** to have the HPV test with my Pap test. I also agree to pay for the HPV test should my insurance not cover the cost.

☐ I have read the above information and **DO NOT** wish to have the HPV test at this time.

X___________________________ Date:_____________________

Patient Signature

____________________________ Patient Name (please write legibly)