All WOMEN'S CARE, PLLC
250 Cherokee Professional Park
Maryville Tn, 37804

chart#

How did you hear about us? _____

Date:_____Social Security Number:_____Date of Birth:_____

Patient Name: _____

Address:_____

_____
City State Zip

Phone (home):_____(cell)_____Can we text you? Yes No

Email* (required): _____

Place of employment:_____Work Phone:_____

Student? Yes No Marital Status: S M D Separated

Language:_____Ethnicity:_____Race:_____

Primary Care Physician:_____Phone: _____

Referred by:_____Phone: _____

Emergency Contact of someone that does not live within the some household:

Name:_____Phone: _____

## INSURANCE INFORMATION**

Primary Insurance:_____

Policyholder name and Date of Birth:_____

Secondary Insurance: _____

Policyholder name and Date of Birth:_____

*** Unless the office is otherwise notified, invoices from this facility will be sent to the email provided on this form. To receive any communication by email you must have access to your patient portal account. If you do not have access set up please ask check-in for details.***

**** All lab work and pathology will be sent to PathGroup Laboratories. Please inform us if you need to use a different lab. ****

**Please initial in boxes as acknowledgment of office policies:**

☐ **Cancellation/No Show and Reschedule Policy:** Our office requires at least 48 hours notice for canceling or rescheduling procedures. Failure to do so can result in a charge up to $100. No shows can also result in a charge up to $100 or discharge from the practice. These fees will be the patient's responsibility and cannot be billed to the insurance company. The first rescheduled procedure will be at no charge (if 48 hours notice is given... for less than 48 hours notice please see above). Every time after the procedure is rescheduled there will be a charge of $20 each time. The rescheduling fee will be he patient's responsibility and will not be billed to the insurance company.

☐ **Assignment of Benefits and Financial Agreement:** I hereby give lifetime authorization for payment of Insurance benefits to be made directly to ALL WOMEN'S CARE, PLLC, and say assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement shall be as valid as the original:

☐ **Consent for Treatment:** I knowingly consent to any treatment, procedures tests, labs, vaccines, and care for which ALL WOMEN'S CARE, PLLC is requested to provide me. I understand my right to question or refuse care. I understand I have released and waived any liability of Facility, Its employees and my physician. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments, care or examinations in the hospital.

**I have received a copy of ALL WOMEN'S CARE, PLLC Notice of Privacy Practices:**

Patient Signature: _____ Date: _____

AWC witness: _____ Date: _____

Chart # _____

ALL WOMENS CARE, PLLC
PHONE (865) 681-0103 FAX (865) 681-9840

# Medical Information Release Form
(HIPPA Release Form)

**Name:** _____ **Date of Birth:** _____

## Release of Information:

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

## Communication:

I prefer communication be made by a: [ ]phone call _____

[ ]email* _____ or [ ]text _____

If unable to reach me by above preferred method:
[ ] you may leave a detailed text message.
[ ] you may leave a detailed message.
[ ] please leave a message asking me to return your call.

The best time to reach me is (day) _____ between (time)_____

* To receive any communication by email you must have access to your patient portal account. If you do not have access set up please ask check-in for details.*

Patient Signature: _____ Date: ____/____/____

AWC witness: _____ Date: ____/____/____

# All Women's Care, PLLC
# Office Policies and Procedures

## Appointments:

- Patients are seen in the office by appointment only. Our office is open Monday through Friday 8:15am-5:15pm, with phones being rolled over to the answering service from 4:30pm-8:30am.

- We send annual and scheduled appointment reminders via text. Please inform the office if you wish to opt out.

- We value your time and will do our best to get you in and out of the office within an hour. Coming in a few minutes early will help us run on time by taking care of paperwork and insurance verification. If you are more than 30 minutes late for an appointment time, we may be forced to move you to the end of the schedule for that day or reschedule your appointment.

- Please come 10 minutes early for your scheduled appointment with your insurance card. Please be prepared to present your insurance card at each visit. All insurance changes are to be reported by the patient. If you do not have your insurance card or provide proof of coverage, you will be considered self pay for that date of service. Correct insurance information ensures that we will meet filing deadlines set by your insurance carrier. If you present the information at a later time we will file as a courtesy, but if the claim is rejected then you will be responsible for the full amount.

- To accommodate patient needs, we have enrolled in multiple insurance programs. While we are pleased to be able to provide service to you, it is very difficult to keep track of all the individual requirements. Plans differ with each individual, even within the same insurance carrier. Providing quality care for our patients is our primary concern. We recommend that you contact your insurance company or read your handbook about your benefits. Insurance is a contract between you and your insurance carrier. We will not become involved in disputes between you and your insurance regarding deductibles, co-insurance, covered charges, pre-existing, etc. You will be billed for any non-authorized office visits. Insurance verification's are an estimate and not a guarantee of benefit responsibility.

- Per the agreement you have with your insurance company, you are required to pay your co-pay at the time of service or your contract requires us to reschedule your appointment.

- We require at least 24 hour notification if you are unable to keep your scheduled appointment. This courtesy allows us to accommodate other patients. We realize emergencies arise, however, we must strictly enforce the policy due to excessive no-shows. Failure to give at least 24 hours advance notice to cancel or reschedule appointments will result in a charge to your account for a missed appointment. Our missed office visit fee is $25.00 with a $100.00 charge for a missed procedure appointment that will need to be paid before your next appointment. . Patients with excessive no-shows may be asked to provide a credit card prior to booking future appointments or discharged from the practice. OB patients cannot miss more than 3 appointments or they will be automatically discharged. If you would like to request special consideration for a no-show, email our office manager jenniferawcobgyn@gmail.com.

**Due to excessive no shows, we regretfully must enforce this no show policy.**

## Understanding your office visit:

- An annual exam (preventive, routine, or wellness) includes an age-appropriate history & physical exam, risk factor review, ordering of routine laboratory test (Pap Smear), and discussion about healthy lifestyle and preventive care.

- A problem-oriented visit addresses specific problems (menopause, depression, bleeding, etc.).

- How your office visit is billed (annual or problem) is determined by what happens during your visit. However, it is possible that your visit may include both annual and problem services, which will be billed accordingly.

## Uninsured/ Self Pay Patients:

- Payment is expected at the time of service.

## Deposits and Payments:

- Surgery Deposits/ OB Deposits/ Devices
  As a courtesy to our patients with insurance we will verify your responsibility prior to services being rendered. The verification obtained is an estimate, and not a guarantee of benefit responsibility. Payments are required prior to your procedure date.

- Statements and Collections
  Monthly statements are sent out and are due upon receipt. At 60 days past due, we will attempt to collect the debt or set up a payment arrangement by phone. If at that time, no payment or arrangement has been made, collection efforts will begin with Revenue Recovery Corporation.

- Payments may be accepted via phone or at our website www.awcobgyn.com under your patient portal. Or you can mail a check to 250 Cherokee Professional Park in Maryville, TN 37804. All methods of payment are free of charge.

- Returned Checks
  There will be a $25.00 handling fee for returned checks. If a second check is presented and returned, we will request that future payments be paid with cash, credit, or debit.

## Acknowledgment of Fees:

- There is a $15.00 fee for FMLA/Disability forms. Please allow 4 business days for completion of these forms. Payment is due when forms are presented.

- When medical records are released directly to the patient there will be a fee of $20.00 for the first 20 pages and $0.25 for every page there after. Please allow 4 business days for completion of these forms. Payments will be expected when the records are picked up.

## Lab/ Prescription Policies:

- All lab work will be billed separately by PathGroup laboratory and is not included in our charges.

- Any billing questions regarding lab work should be addressed with the laboratory.

- Lab results are available in our patient portal. Results that require follow up will be done so by telephone. Results can take up to 10 business days (usually less). Please contact our office regarding results for routine visits if you have not received results within this time frame. We do understand that waiting for results can be worrisome. Getting results back and to the patient as quickly as possible is our goal. If patients call before this time period we often spend time stating the results are not back yet and this delays staff working on calling patients whose results have arrived. If you had a critical test or a non-routine visit and are particularly worried please call. If you would like us to contact you via email, text or by phone with normal lab results, instead of checking portal, please let a member of our front office staff know.

- We require 48 hours for refill requests. Do not call our after hours service to request refills.

### Patient Portal:

- All Women's Care, PLLC offers a secure patient portal as a service to our patients that wish to view their records and communicate with our office. We encourage all of our patients to sign up for this service as a valuable communication tool, however the portal is not to be used in Emergency or Urgent matters. While on the portal you can view lab results and records, make a payment on your account, or email the office.

- **Register for the patient portal at www.awcobgyn.com.**

### Telephone Calls:

- Phone calls and messages received are triaged by our office to the appropriate staff member. Calls are returned by priority and non urgent calls received after 4pm will be handled the next business day. Please know we will make every attempt possible to return calls in a timely manner.

### After Hours & Emergency Care:

- If you are experiencing a life-threatening emergency, dial 911 or go to the nearest emergency room. For established patients, OB and Gyn emergency care is available after hours. The answering service is available 24 hours a day 7 days a week. Please use this service for emergencies only. If an after hours call is deemed non-emergent, a fee of $25 will be billed to you.

**We would like to thank you in advance for your cooperation and understanding of our policies and procedures.**

_____Initials **I understand my lab results are available on my patient portal and if I want to receive my results via phone, email or text I must notify the front office staff.**

**Signature:**_____ **Date:**_____

**All Women's Care, PLLC**
**NOTICE OF PRIVACY PRACTICES**
**EFFECTIVE March 19, 2019**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.** You have the right to a paper copy of this Notice; you may request a copy at any time.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.**

We may use and disclose your health information for the following purposes without your express consent or authorization.

***Treatment.*** We may use your health information to provide you with medical treatment. We may disclose information to doctors, nurses, technicians, medical students, or other personnel involved in your care. We also may disclose information to persons outside our organization involved in your treatment, such as other health care providers, family members, and friends.

We may use and disclose health information to discuss with you treatment options or health-related benefits or services or to provide you with promotional gifts of nominal value. We may use and disclose your health information to remind you of upcoming appointments. Unless you direct us otherwise, we may leave messages on your telephone answering machine identifying our organization and asking for you to return our call. We will not disclose any health information to any person other than you except to leave a message for you to return the call.

***Payment.*** We may use and disclose your health information as necessary to collect payment for services we provide to you. We also may provide information to other health care providers to assist them in obtaining payment for services they provide to you.

***Health Care Operations.*** We may use and disclose your health information for our internal operations. These uses and disclosures are necessary for our day-to-day operations and to make sure patients receive quality care. We may disclose health information about you to another health care provider or health plan with which you also have had a relationship for purposes of that provider's or plan's internal operations.

***Business Associates.*** We provide some services through contracts or arrangements with business associates. We require our business associates to appropriately safeguard your information.

***Creation of de-identified health information.*** We may use your health information to create de-identified health information. This means that all data items that would help identify you are removed or modified.

***Uses and disclosures required by law.*** We will use and/or disclose your information when required by law to do so.

***Disclosures for public health activities.*** We may disclose your health information to a government agency authorized (a) to collect data for the purpose of preventing or control disease, injury, or disability;

or (b) to receive reports of child abuse or neglect. We also may disclose such information to a person who may have been exposed to a communicable disease if permitted by law.

***Disclosures about victims of abuse, neglect, or domestic violence.*** We may disclose your health information to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

***Disclosures for judicial and administrative proceedings.*** Your protected health information may be disclosed in response to a court order or in response to a subpoena, discovery request, or other lawful process if certain legal requirements are satisfied.

***Disclosures for law enforcement purposes.*** We may disclose your health information to a law enforcement official as required by law or in compliance with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer; a grand jury subpoena; or an administrative request related to a legitimate law enforcement inquiry.

***Disclosures regarding victims of a crime.*** In response to a law enforcement official's request, we may disclose information about you with your approval. We may also disclose information in an emergency situation or if you are incapacitated if it appears you were the victim of a crime.

***Disclosures to avert a serious threat to health or safety.*** We may disclose information to prevent or lessen a serious threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

***Disclosures for specialized government functions.*** We may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

***Disclosure for fundraising.*** We may disclose demographic information and dates of service to an affiliated foundation or a business associate that may contact you to raise funds for our organization. You have a right to opt out of receiving such fundraising communications.

***Disclosure for remunerated treatment communications.*** We may disclose your information for the purposes of communicating treatment alternatives or health-related products or services when we receive payment for your information in exchange for making the communication. You have a right to opt out of receiving such communications.

## OTHER USES AND DISCLOSURES

We will obtain your express written authorization before using or disclosing your information for any other purpose not described in this notice. For example, authorizations are required for use and disclosure of psychotherapy notes, certain types of marketing arrangements, and certain instances involving the sale of your information. You may revoke such authorization, in writing, at any time to the extent we have not relied on it.

## YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

**Right to Inspect and Copy.** You have the right to inspect and copy health information maintained by us. To do so, you must complete a specific form providing information needed to process your request. If you request copies, we may charge a reasonable fee. We may deny you access in certain limited circumstances. If we deny access, you may request review of that decision by a third party, and we will comply with the outcome of the review.

**Right To Request Amendment.** If you believe your records contain inaccurate or incomplete information, you may ask us to amend the information. To request an amendment, you must complete a specific form providing information we need to process your request, including the reason that supports your request.

**Right to an Accounting of Disclosures and Access Report.** You have the right to request a list of disclosures of your health information we have made, with certain exceptions defined by law. You also may request an access report indicating who has accessed your PHI maintained by us or our business associates in an electronic designated record set in the last three years. To request an accounting, you must complete a specific written form providing information we need to process your request.

**Right to Request Restrictions.** You have the right to request a restriction on our uses and disclosures of your health information for treatment, payment, or health care operations. You must complete a specific written form providing information we need to process your request. Our Privacy Officer is the only person who has the authority to approve such a request.

**Right to Request Alternative Methods of Communication.** You have the right to request that we communicate with you in a certain way or at a certain location. You must complete a specific form providing information needed to process your request. Our Privacy Officer is the only person who has the authority to act on such a request. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

## COMPLAINTS

If you believe your rights with respect to health information have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact our Privacy Officer, Jennifer Versa at 865-681-0103. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

We reserve the right to change the terms of this Notice and to make the revised Notice effective with respect to all protected health information regardless of when the information was created.