All Women's Care, PLLC
250 Cherokee Professional Park
Maryville Tn, 37804

chart#: _____
Date:_____

How did you hear about us? _____

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 Widowed

Language:_____Ethnicity:_____Race:_____

Primary Care Physician:_____Phone: _____

Preferred Pharmacy:_____ 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:_____

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

By signing below I acknowledgee that I have received a copy of All Women's Care, PLLC's office policies.

Patient signature: _____ Date: _____

AWC staff signature: _____ Date: _____

Revised 10/28/19

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:
Per office policies, most outgoing communication from the office will be made through patient portal. Such as, normal lab and ultrasound results and medication refills.
You may also provide a secondary form of communication.

I prefer my secondary form of communication be made by:
[ ]phone call _____ **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)_____

By signing below I understand that my results will be available to me on my patient portal.
I also acknowledge that I have reviewed the privacy practices provided by All Women's Care, PLLC and that I may request a copy at my discretion.

Patient Signature: _____ Date: ____/____/____

AWC witness: _____ Date: ____/____/____

revised 10/28/19

ALL Woman's Care, PLLC
250 Cherokee Professional Park
Maryville, Tn 37804
phone: (865) 681-0103 fax: (865) 681-9840

Authorization to obtain/release medical information

Patient Name (print) _____ SS or Health Record number _____ Patient DOB _____

_____ I authorize All Women's Care, PLLC to obtain/release my health information as described below.

Please identify the information to obtained/released:

☐Please obtain/release my entire medical record

-OR-

☐Please obtain/release *only* the folling information (check appropriate boxes and include other information where indicated):

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Most recent history
- ☐ Most recent discharge summary
- ☐ Lab results (please describe the dates or types of lab tests you would like disclosed): _____
- ☐ X-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed): _____
- ☐ Consulation reports (please supply doctors' name/s): _____
- ☐ Other (please describe):

The identified information will be used for the following purpose:

- ☐ My personal records
- ☐ Sharing with other health care providers as needed
- ☐ Other (please describe):_____

Please initial each item below to indicate your understanding

_____ I understand the information in my health record may include information relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ I understand once the information below is obtained/released it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or tegulations.

_____ I understand I have a right to revoke this authorzation at any time. I understand if I provoke this authorization, I must do so in writing and present my written revocation to the pracice. I understand the revocation will not apply to information that has already been obtained/released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand the authorization of this release is voluntary. I need not sign this form to unsure health care treatment.

The indentified information may be obtained/released from/to the following individual(s) or organization(s):

	Name: _____		Name: _____
TO:	Address: _____	FROM:	Address: _____
	Phone: _____		Phone: _____
	Fax: _____		Fax: _____

This authorization will expire on (insert date or event): _____
If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ _____
Patient Signature (or Signature of person completing for if not patient*) Date
*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other: _____

_____ _____
AWC Staff Witness Signature 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. 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.

- 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.

Consent for Treatment:

- I knowingly consent to any treatment , procedures, labs, vaccines, and care for which All Women's Care, PLLC is requested to provide me. I understand my right to question and refuse care. I understand I have released and waived any liability of facility, its employees, and my physicians. 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.

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:_____