659 S. Salisbury Blvd. Suite 4
Salisbury MD 21801
Phone: (410)543-9111 Fax (410)543-9115

ABOUT OUR PHYSICIANS AND SERVICES

Thank you for choosing our facility for your care. Our providers practice state-of-the-art specialty care in Gynecology and strive to provide the best evidence-based medicine to our valued patients.

Our focus is the prevention of disease and the treatment of complications. To serve our patients better, we are offering as many services in our office as possible.

OFFICE HOURS. Our office hours are by appointment only, Monday thru Friday from 8 am to 6 pm. Hours are subject to change.

REFERRALS AND INSURANCE. Please bring your insurance card, photo ID and your referral (if your insurance requires one). If your insurance requires a referral and you do not have it with you, you will be rescheduled.

If we participate with your insurance, we will file a claim for you. Please understand that any charges denied by your insurance company or that are not covered by your insurance company will become your financial responsibility. It is your responsibility to know if there is a pre-existing clause or a maximum allowable amount on your insurance. If your insurance denies a claim due to a pre-existing condition or because you have passed your maximum allowed amount, the bill will become your financial responsibility.

Co-pays are due at the time of service. We accept cash, check, Visa, Master Card or Discover.

There is a $75.00 fee if you do not show for your scheduled appointment or if you do not give 24 hour notice of cancellation. _____ *Initials required*

REQUEST FOR FORMS AND MEDICAL RECORDS. If you request a copy of your medical records to be sent to another physician (with your written permission) there will be a charge of $.73 a page and an additional $22.18. If you want to pick the records up in our office there is only a charge of $.73 a page. If you want your records mailed, there will be an addition fee for postage along with the regular fees. Fees must be paid in full before records are released.

PHONE CALLS AND MESSAGES. Mondays and Fridays are our busiest days for phone calls. If we are unable to answer your call, please leave a voice message. The voice mail is checked several

times throughout the day. Please allow 24 to 48 hours for a return call. If your call is urgent, please state so and someone will call you back by the end of the day.

PRESCRIPTIONS. We ask that you have a list of all medications you need when you come for your visits. We can mail your prescriptions to you or call them into the pharmacy. However, if you need to call for a refill, please allow 48 hours. It is best to have your pharmacy send a prescription refill request to us. **PLEASE DO NOT PAGE THE PROVIDERS FOR MEDICINE REFILLS**.

HIPAA LAWS. Patient privacy is very important to us. We cannot discuss your medical information with anyone unless you list their name in the patient contact information sheet. If you would like a copy of our HIPAA form, please ask the receptionist. ALL patients18 y/o and OVER must sign all forms themselves and designate who medical information can be released to.

I AGREE TO TAKE AN ACTIVE PART IN MY HEALTH CARE BY KEEPING MY FOLLOW-UP VISITS AND HAVING LAB WORK DONE AS ADVISED BY MY PHYSICIAN. I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND POLICIES AND AGREE TO ALL THE TERMS STATED.

Name: _____

Date: _____

Witness: _____

Center for Women's Health
SALISBURY
Healthcare Every Woman Deserves

Patient Registration Sheet

Today's Date: _____

Patient name: _____ DOB: _____
LAST FIRST MIDDLE INIT

Primary Mailing Address: _____

City: _____State: _____ Zip: _____

Home Phone: _____Work Phone: _____Cell #: _____

Social Security #:_____ Sex: M or F Marital Status: S or M

Living Will: Y or N **Organ Donor:** Y or N **Student Status**: Non-student PT FT

Secondary Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Patient's Employer name: _____ Employer phone #: _____

Employer address: _____

Primary Insurance: _____ Insurance ID #: _____

Insurance Group #: _____ Insurance Phone #: _____

Policyholder's Information

Name: _____ DOB: _____ Social Security #: _____

Employer: _____ Phone: _____

Secondary Insurance: _____ Insurance ID #:_____

Insurance Group #: _____ Insurance Phone # :_____

Policy Holder's Name: _____ DOB: _____

Do you need a referral to see a specialist: Yes or No; If yes, did you already request a referral? Yes or No

Primary Care Physician: _____ **Copay**: $ _____

Emergency Contact: _____ Phone #: _____

Relationship: _____

How did you hear about us? _____

Center for Women's Health
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Patient Contact Sheet

Please Check All That Apply

_____ I give you permission to call me at home.
____ You may leave a detailed message here.

_____ I give you permission to call me at work.
____ You may leave a detailed message here.

_____ I give you permission to call my cell phone.
____ You may leave a detailed message here.

_____ You may **email** me at: _____

___Please send my **mail**, including my bills to this address:

_____ Home address

_____Alternate Address _____

_____

___ You may **text** me appointment reminders to: _____

___ I do not wish to share my medical records with anyone at this time.

___ Person(s) authorized to discuss my medical information (please check billing, clinical or both):

Name:_____ Relationship: _____ __ Billing __ Clinical

Name:_____ Relationship: _____ __ Billing __ Clinical

Name:_____ Relationship: _____ __ Billing __ Clinical

I understand that the medical provider to whom I am making this request will make reasonable efforts to accommodate this request. I understand that I must provide an alternate address to receive bills and statements or my home (or primary) address will be used. I further understand that in some emergency situations my protected health information may be released.

Patient (guardian) Signature: _____ Date: _____

Revision Date 2/28/2014

Patient Consent for Use and Disclosure of Protected Health Information

I have been offered a written copy of the Notice of Privacy Practices of Center for Women's Health prior to signing this consent. Center for Women's Health reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices will be posted in the office or may be obtained by forwarding a written request to *Privacy Officer, 659 South Salisbury Blvd, Suite 4, Salisbury Maryland 21801*.

I hereby give my consent for Center for Women's Health to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Center for Women's Health describes such uses and disclosures more completely.)

With this consent, Center for Women's Health may call my home or other alternative location and leave a message on voice mail, answering machine or with a person in reference to any items that assist the practice in carrying out TPO. Such items include appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, Center for Women's Health may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, test results and patient statements.

With this consent, Center for Women's Health may e-mail to my home or other alternative location (or text to my cell phone) any items that assist the practice in carrying out TPO, such as appointment reminders, test results and patient statements.

I have the right to request, in writing, that Center for Women's Health restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Center for Women's Health may decline to provide treatment to me.

Patient Name: _____

Signature: _____ Date: _____

If not patient, name of legal guardian: _____ Relationship: _____

****

Internal Use Only:
If patient or patient's representative refuses to sign acknowledgement of receipt of notice and/or consent to disclose PHI, please document date and time the notice was presented to patient and sign below.

Presented on (date & time): _____ By (name & title): _____

Revision Date 10-04-2013

Center for Women's Health
SALISBURY
Healthcare Every Woman Deserves

Acknowledgement of Receipt of Privacy Notice
Authorization for Treatment and Financial Agreement

I have been offered a written copy of Center for Women's Health's **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand my rights as described in this notice.

I hereby apply for treatment by Center for Women's Health, physicians and/or their assistants. Such treatments include injections and such other office procedures as they deem medically necessary.

Further, I permit a copy of this authorization to be used in place of this original, and authorize the filing of any insurance claims in force and direct payment to Center for Women's Health, of any amounts due. I understand I am financially responsible for charges not covered by benefits due under this authorization and accept full responsibility for such charges. Regulations pertaining to medical assignment of benefits apply. I further understand that should my insurance have a copay, I am required to pay it on the day of service.

If I do not sign this consent, or later revoke it, Center for Women's Health may decline to provide treatment to me.

Patient Name: _____

Signature: _____ Date: _____

If not patient, name of legal guardian: _____ Relationship: _____

****

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice and/or consent to disclose PHI, please document date and time the notice was presented to patient and sign below.

Presented on (date & time): _____ By (name & title): _____

The Center for Women's Health

PRIVACY & BILLING PROCEDURES
AUTHORIZATION & ACKNOWLEDGEMENT

These authorizations, acknowledgements and waivers cover all services rendered to the above patient for today and all futures dates of service. You may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any events that occurred before you notified us of your decision to revoke.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Center for Women's Health reserves the right to modify the privacy practices outlined in the Notice of Privacy Practices. I have had the opportunity to read or have received a copy of the Notice of Privacy Practices for the Patient outlined above.

AUTHORIZATION TO TREAT & BILL

I give consent and authorization to The Center for Women's Health to examine and provide all routine medical care, diagnostic procedures, disposing of any specimens or tissue taken from my body, and provide treatment which provide in the judgment of the medical provider, may be necessary or beneficial to my health and well being with no guarantees expressed regarding the results of examination and treatment by aforementioned facility.

I authorize the release of any medical and demographic information necessary to process all claims. I authorize payment of medical benefits to The Center for Women's Health for all services performed.

I understand that I am responsible for all charges incurred at the time of service unless other arrangements were made prior to being treated. I will pay any deductible, co-payment, co-insurance, and any amounts denied or not covered by insurance. I understand it is my responsibility to check with my insurance carrier prior to my visit for covered and non-covered benefits and whether or not The Center for Women's Health visit will be paid with my in-network or out-of-network benefits billed as urgent care place of service (POS 11).

I understand that if I do not provide complete and accurate billing/Insurance information at the time of service and this lack of information prevents The Center for Women's Health from collecting from my insurance company, I will be responsible for the full charges. If a referral or additional forms are required by my insurance company, I understand I am responsible for providing The Center for Women's Health with a referral within 48 hours of my visit and/or complete all insurance required forms in a timely manner, or I may be responsible for all charges.

Interest: Invoices and bills for treatment will bear interest at the rate of 18% per annum (1.5% per month) 30 (thirty) days after the date of service until fully paid.

Collection Fees: If payment is not made as agreed upon, the account will be turned over for collection. The patient, and/or guarantor, shall be responsible for and agree to pay all reasonable cost of collection including, but not limited to, reasonable collection agency fees, attorney's fees, and court costs.

Jurisdiction and Venue: If any suit must be filed to collect an unpaid balance on an account, patient, and/or guarantor, agrees that such suit may be brought in courts of Wicomico County, Maryland, and waives any objection to jurisdiction or venue.

Assignment & Release: I hereby request and assign directly to The Center for Women's Health all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, including collection fees and/or interest that may accrue, whether or not paid by insurance. I hereby authorize the Provider to release all information necessary to secure the payment of benefits unless written notice is given to revoke this authorization. I authorize the use of a copy of this signature is as valid as the original signature on all of my insurance submissions. Co-pays and/Quick Pay fees are due at the time of service. All account balances will be the patient's and/or guarantor's responsibility after processing of insurance, if applicable, and may be assessed a $15.00 statement fee per invoice. Full balance is due within 15 days or upon receipt of the first invoice. If you have signed the convenient EZPAY form, you will receive an invoice with the balance due after insurance submission. If the invoice is not paid within 10 days and you do not contact us with an alternate form of payment, the signed EZPAY will be used to bring the account up to date. If card is declined, a $15 fee may apply. The Center for Women's Health (Women's Healthcare of Delmarva) is not responsible for any overdraft fees if a bank card is provided as EZPAY. *** CFWH does not participate with any Medical Assistance.**

► PLEASE SIGN HERE: PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE: _____ DATE: _____

OUTSIDE LABORATORY, RADIOLOGISTS & ANESTHESIOLOGISTS

It is my understanding that The Center for Women's Health may send lab specimens to an outside laboratory or have an anesthesiologist present for procedures they provide to you at our facility. I give permission for those outside laboratories and Anesthesiologist to bill my insurance for their services. I understand that I may incur additional charges as a result of those outside laboratory tests and Anesthesiologist. I understand that The Center for Women's Health is not responsible for payment to those laboratories and/or Anesthesiologists.

► PLEASE SIGN HERE: PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE: _____ DATE: _____

NON-COVERED SERVICES

It is my understanding that my insurance company may deem my visit to The Center for Women's Health as a non-covered service and may make me fully responsible for payment of all charges for these services. I also acknowledge that I am aware that The Center for Women's Health **does not** participate with any Medical Assistance.

► PLEASE SIGN HERE: PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE: _____ DATE: _____

Center for Women's Health
SALISBURY
Healthcare Every Woman Deserves

Patient Intake Form

Patient's Name: _____ Today's Date: _____

Reason for visit: _____

_____

Primary Doctor: _____ Pharmacy: _____

Last Menstrual Period: _____

Please answer the following questions by checking the appropriate box:

Energy Level ☐ Low ☐ Moderate ☐ High

Are you sleeping well? ☐ Yes ☐ No How many hours: _____

Are you taking adequate calcium? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No Gym or At Home? (circle one) How often: _____

Are you sexually active? ☐ Yes ☐ No

Are you currently taking birth control: ☐ Yes ☐ No Method: _____

Do you have decreased sex drive? ☐ Yes ☐ No

Do you perform self breast exams? ☐ Yes ☐ No

Social History

Do you smoke? ☐ Yes ☐ No How much? _____

Do you drink alcohol? ☐ Yes ☐ No How much? _____

Do you use illicit drugs? ☐ Yes ☐ No Please list: _____

Do you consume caffeine? ☐ Yes ☐ No How much? _____

Living situation: _____

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated Other: _____

Work Status: ☐ Full-Time ☐ Part-time ☐ Unemployed ☐ Stay at home Other: _____

Pregnancy History

Have you ever been pregnant? ☐ Yes ☐ No How many times: _____

# of Abortion: _____ # of Miscarriages: _____ # of living children: _____

Delivery Mode: _____

Health Maintenance:

Date of last Pap Smear: _____ History of abnormal paps? ☐ Yes ☐ No

Date of last Mammogram: _____ Date of last Dexa Scan: _____

Date of last Colonoscopy: _____

Have you ever had abnormal results on any testing (dexa scans, mammograms, bloodwork, etc.)? _____

_____

Family History

Please list any family members who have had any of the following conditions:

Cancer: _____

Heart Disease:_____

Diabetes: _____

Osteoporosis: _____

Hypertension: _____

Thyroid Problems: _____

Allergies

Please list all allergies and the specific reaction: _____

_____

_____

Medications

Please list all medications including the dosage and how often you take them:

MEDICATION	DOSAGE	HOW OFTEN

Past Surgeries

Please list any surgeries you have had:

Surgery Name	Year