UNIVERSITY of MARYLAND
BALTIMORE WASHINGTON
WOMEN'S HEALTH ASSOCIATES

7556 Teague Road #430
Hanover, Md 21076
410-553-8260 x 2

203 Hospital Drive #308
Glen Burnie, Md 21061
410-553-8260 x 3

4231 Postal Court #102
Pasadena, Md 21122
410-553-8260 x 4

Dear Patient,

Thank you for choosing *Baltimore Washington Women's Health Associates* to provide you with the highest quality Obstetric and Gynecologic healthcare.

Your appointment is scheduled for _____ at

_____am/pm with Dr. _____.

Enclosed is a New Patient packet that contains a *Patient Demographics Form* and the *Consents and Assignments* for you to complete and bring with you to your scheduled visit to our office. **PLEASE COMPLETE AND READ THE FORMS IN ITS ENTIRETY.** Along with this completed packet, it is important that you bring your **photo ID, insurance cards and comprehensive list of medications**.

Please be informed that the *University of Maryland Baltimore Washington Medical Center Notice of Privacy Practices*, is available for your review on our website at www.bwwomens.com. Copies are also available upon request at each location.

Should you have any questions or require any changes in your scheduled appointment, please call our office at the number indicated above. **If you must cancel your appointment, please give us a minimum of 24 hour notice. Also, if you are 15 minutes or more late for a scheduled appointment, we will make every effort to accommodate you. You may be given the option to see another physician, be scheduled during or at the end of the current session, or you may need to be rescheduled."**

We look forward to seeing you on the day and time indicated above.

Sincerely,

Providers, Management and Staff
Baltimore Washington Women's Health Associates

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PLEASE PRINT CLEARLY

Name (Last, First, MI):_____

Home Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____ Email: _____

Date of Birth: _____ Soc. Sec. #: _____ Marital Status:_____

Race: ☐American Indian or Alaskan ☐Asian ☐Black or African American ☐White
☐Native Hawaiian or Pacific Islander ☐Two or more races ☐Other ☐Declined ☐ Unknown

Employer:_____Occupation:_____

Referring Physician:_____ Phone #:_____

Primary Care Physician:_____ Phone #:_____

INSURANCE INFORMATION

Primary Insurance Company Name: _____

Primary Insurance Company Address: _____

Policy/ID# : _____ Group/Employer #: _____

Subscriber Name: _____ Relationship:_____

Subscriber Date of Birth:_____ Subscriber Soc. Sec. #:_____

Subscriber's Employer:_____

Secondary Insurance Company Name: _____

Secondary Insurance Company Address:_____

Policy/ID# : _____ Group/Employer #: _____

Subscriber Name: _____ Relationship:_____

Subscriber Date of Birth:_____ Subscriber Soc. Sec. #:_____

Subscriber's Employer:_____

EMERGENCY CONTACT INFORMATION

Name (Last, First, MI):_____ Relationship: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____ Email: _____

UNIVERSITY of MARYLAND
BALTIMORE WASHINGTON
WOMEN'S HEALTH ASSOCIATES

CONSENTS AND ASSIGNMENTS

PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITY AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION: Name the persons you are authorizing **Baltimore Washington Women's Health Associates** to disclose your protected health information regarding treatment, payment and other healthcare operations in the event you are not available.

_____

Print Name of Authorized Person | Relationship | Phone number

_____

Print Name of Authorized Person | Relationship | Phone number

AUTHORIZATION FOR USE OF VOICE MAIL OR EMAIL: Healthcare staff are routinely unable to contact patients directly during normal business hours. On these occasions our staff may leave messages on communication devices provided by our patients or send messages via email. Due to the HIPPA Privacy Rule we must obtain your authorization to continue to use this mode of communication.

_____(Initial) **YES**, I agree to allow the healthcare staff of **Baltimore Washington Women's Health Associates** to leave and/or send messages via the following communication methods:

_____ Home voice mail _____Work voice mail _____Cell voice mail _____Email Email address_____

_____(Initial) YES, I hereby expressly consent to the placing of autodialed or prerecorded health care-related calls to my cell phone number

_____(Initial) **NO**, I do not agree to allow the healthcare staff of **Baltimore Washington Women's Health Associates** to leave messages on my communication devices.

RELEASE OF INFORMATION: I authorize **Baltimore Washington Women's Health Associates** to release information from my medical record to any person, corporation or agency legally responsible for processing and/or paying of any part of the center's charges and/or professional fees. I also authorize release to healthcare workers/providers/consultants who are directly involved in my care. Release of information to any other party than that stated above will require separate authorization. A copy of **Baltimore Washington Women's Health Associates "***Notice of Information Privacy Practices"* HIPPA Notification is available on our website bwwomen.com and upon request in the office.

ASSIGNMENT OF BENEFITS: In the event that I am entitled to benefits arising out of my medical insurance policy or contract of insurance benefits, I assign these benefits to **Baltimore Washington Women's Health Associates.** I also assign benefits payable for physician services to **Baltimore Washington Women's Health Associates.**

CONSENT FOR CARE: I hereby give consent to the providers of **Baltimore Washington Women's Health Associates** to examine, make an assessment and recommend the appropriate treatment for my condition. I also consent to the collection and testing of specimens required for the diagnostic evaluation of my symptoms/condition.

PATIENT FINANCIAL RESPONSIBILITY: I understand that I am responsible for charges considered to be 'non-covered' by my insurance and/or for charges incurred without referral. I understand that I am contractually obligated by my insurance company to pay my copayment and I will make payment at each applicable visit. Any attempt to withhold other insurance information, misrepresent my coverage or not disclose other coverage is considered insurance fraud which may subject me to penalties and/or ejection from the practice. I further understand that it is my obligation to know my insurance coverage and it is not the responsibility of this provider.

LABORATORY SERVICES: Please contact your insurance company for any questions/concerns regarding coverage and benefits. You, as the patient, are responsible for having your labs performed by your contracted lab to receive the highest level of benefits. If you do not know your contracted lab please contact your insurance company.

Print Name: _____

Signature: _____ Date: _____

Revised October 2015