HIPAA - Patient Consent Form

PATIENT CONSENT FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient Name: ______________________________ Date of Birth: ____________________

SSN: ________________________ Previous / Other Names (s): _________________________

I understand that the patient's health information is private and confidential. I understand that Cherokee Women's Health Specialists works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Cherokee Women's Health Specialists may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosure of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission.

Cherokee Women's Health Specialists has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I will have a right to read the "Notice" before signing this agreement.

Cherokees Women's Health Specialists may update this "Notice of Privacy Practices". If I ask Cherokee Women's Health Specialists will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Cherokee Women's Health Specialists to limit how the patient's personal health information is used or disclosed to carry out treatment, payment, or health care operations understand that Cherokee Women's Health Specialists does not have to agree to my request. If Cherokee Women's Health Specialists does agree to my request, I understand that Cherokee Women's Health Specialists would follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

1) Signing and dating a form that Cherokee Women's Health Specialists can give me called "Revocation of Consent for Use and Disclosure of Health Care Information", or

2) Writing, signing, and dating a letter to Cherokee Women's Health Specialists. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

If I revoke this consent, Cherokee Women's Health Specialists does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of Cherokee Women's Health Specialists "Notice of Privacy Practices". My signature means that I agree to allow Cherokee Women's Health Specialists to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

Patient/Legally-Authorized Signature: ____________________________ Date: ______________

Relationship to patient if signed by anyone other than patient: ______________________________

We Welcome you to our office as a new gynecological patient:

Please read the following information below very carefully before you sign at the bottom. We will be happy to answer any questions you may have.

Medicare: We will file your claim for you, however you are responsible for any service not covered by your plan, your deductible or patient liability.

Medicaid: We do accept Medicaid and will file your claims, however you must bring a valid card in at each visit or you are liable for the charges of that day.

HMO's and PPO's: If you are under an HMO or PPO plan we will file your claims for your, however, you are responsible for your co-pay, deductible, or any charges that are not covered by your insurance plan.

Assignment: Please check with the front office and we will be glad to answer questions regarding your insurance plan, but it is the patient's responsibility to check with their insurance company regarding provider/ doctor participation. You will be responsible for your deductible and any charge that your insurance does not cover.

All Others: If we are not on your insurance plan, you are expected to pay IN FULL TODAY. We will give you the proper paperwork to file with your insurance.

Self-Pay: You are responsible for your charges and will be expected to make payment in full today, unless you have made previous arrangements with our billing department.

Please provide your signature and today's date for our records verifying that you have read and understand this document.

I authorize the release of any medical information necessary to process insurance claims. I authorize and permit payment directly to the Doctor. I recognize and accept responsibility for any balance remaining after payment of such benefits.

____ ____________________

Patient Signature | Date

Administrative Patient Information

Name (Last, First, Middle)		SSN#	
Date of Birth	Age	Marital Status	Maiden Name
Address		City, State, Zip Code	
Patient Home Phone	Patient Cell Phone/Pager	Patient E-mail	
Patient Business Phone	Patient Employer	Patient's Occupation	
Business Address		City, State, Zip Code	

Spouse/Parent/Guardian Name (If under age 18)		Employer
Address		City, State, Zip Code
Business Phone	Alternative Phone	Relationship (Parent, Spouse, Guardian)
In Case of Emergency		Phone
Do you have a living will? Yes No	Who referred you to our practice?	

Primary Insurance		Secondary Insurance	
Address		Address	
City, State, Zip Code		City, State, Zip Code	
Phone	Co-Pay	Phone	Co-Pay
Insured Party ID#		Insured Party ID#	
Group ID#		Group ID#	
Name of Insured		Name of Insured	
Sex	Date of Birth	Sex	Date of Birth
Employed by		Employed by	
Relationship to Patient		Relationship to Patient	

***Payment is due at time of service. ***
Assignment and Release: I, the undersigned, certify that I (or my dependent) have insurance coverage as stated above and assign to Cherokee Women's OB/GYN, P.C., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am fully responsible for all charges not paid by my insurance company. I hereby authorize this practice to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submission. I fully understand that any lab work performed will be billed by that lab, independently.

Patient's Signature	Date

Cherokee Women's Specialists
EMR History Intake Form

Patient Name ______________________

Date of Birth ______________________

Last Menstrual Period Date ______________________

Briefly state your reason for visit ______________________

ALLERGIES/REACTIONS Please list any drug, food or environmental allergies and your reaction	

FAMILY Please list any family medical history, i.e., heart disease, diabetes, cancer, etc.

Disease	Family Member	Disease	Family Member

PAST MEDICAL	
Date of Last Pap:	Abnormal (Circle) Yes No
History of abnormal pap? Yes No	If yes, list treatment
Date of Last Mammo:	Abnormal (Circle) Yes No
History of abnormal mammo? Yes No	If yes, list treatment
Date of Last Bone Density:	Abnormal (Circle) Yes No

GYN HISTORY
Age period began:
# of days between periods:
Flow/Duration of period:
Painful Periods (Circle) Yes No
Age Menopause began:
Painful Intercourse (Circle) Yes No
Do you ever experience leaking of urine? (Circle) Yes No
Blood Transfusion (Circle) Yes No

List Past GYN Problems	List Other Medical Problems	List Surgeries

Pregnancy History:

# of Pregnancies ____________ # of Abortion/Miscarriages ___________ # of Living Children ___________

Pregnancy Details:

	1st Pregnancy	2nd Pregnancy	3rd Pregnancy	4th Pregnancy	5th Pregnancy
Date					
GA Weeks					
Complications					
Delivery Type					
Length of Labor					
Birth Weight					
Sex					
Analgesia / Anesthesia					
Treatment of Preterm Labor					
Induction					
Laceration/ Episiotomy					
Place of Delivery					

SOCIAL
Marital Status:
Primary Occupation:
Primary Birth Control Method:
Are you sexually active? (Circle) Yes No

SOCIAL			
Do you exercise? (Circle) Yes No		Days per week?	

Tobacco Use? Yes No	Alcohol Use? Yes No	Drug Use? Yes No	Caffeine Use? Yes No
Amount:	Amount:	Amount:	Amount:

MEDICATIONS: Please list any medications the patient is currently taking			
Medication Name	Strength/Dose	Medication Name	Strength/Dose

Pharmacy Information		
Name	Locations	Phone Number