

**Women's Health Group of S.E. Georgia  
3300 Fourth St.  
Brunswick, Georgia 31520  
912-267-0884**

Dear Patient,

Please complete the enclosed forms and return them to our office with a **copy of your insurance card (front and back)** prior to your appointment. If there is not adequate time to mail the forms, please return them by one of the following methods listed below. This will help to prevent any delays in your appointment.

**Forms may be submitted by any of the following methods:  
Attn: Edith Fiveash / Scheduling Coordinator**

- Fax to 912-267-6537
- E-mail to [scheduling@whgobgyn.com](mailto:scheduling@whgobgyn.com)
- By mail to above address
- Bring to office at least 48 hours in advance of your appointment

If you are unable to keep your scheduled appointment, please call the office as soon as possible to cancel or reschedule. We look forward to your visit with our practice and thank you for choosing Women's Health Group.

Women's Health Group of S.E. Georgia  
Mark K. Norvell, M.D.  
John Ellenberg, M.D.  
Matthew Johnston, M.D.  
Tina Mitchell, M.D.

**PATIENT REGISTRATION FORM**

**2010**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Pager: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Who referred you to our Practice: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Who is your Family Physician: \_\_\_\_\_ Phone \_\_\_\_\_ Email: \_\_\_\_\_

**FINANCIAL RESPONSIBILITY IF OTHER THAN SELF**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 What is the relationship of the financially responsible person to the patient?:  Spouse  Mother  Father  Other \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Name of Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**COMPLETE BELOW ONLY IF YOU ARE NOT PRIMARY POLICY HOLDER**

Policy Holder Name: \_\_\_\_\_ What is your relationship to policy holder? \_\_\_\_\_  
 Policy Holder Date of Birth: \_\_\_\_\_ Policy Holder Social Security#: \_\_\_\_\_  
 Policy Holder Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Name of Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**COMPLETE BELOW ONLY IF YOU ARE NOT PRIMARY POLICY HOLDER**

Policy Holder Name: \_\_\_\_\_ What is your relationship to policy holder? \_\_\_\_\_  
 Policy Holder Date of Birth: \_\_\_\_\_ Policy Holder Social Security#: \_\_\_\_\_  
 Policy Holder Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

**EMERGENCY CONTACT**

Name of Emergency Contact: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Women's Health Group or insurance company to release any information required to process my claims. I also request, in case of emergency, to contact the appropriate individual and, if necessary, disclose any health care information.

Responsible party / Guardian signature \_\_\_\_\_

Date \_\_\_\_\_

# HISTORY

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Previous Marriage: Yes \_\_\_\_\_ No \_\_\_\_\_

**Pregnancy History:** Total Number: \_\_\_\_\_ Full term: \_\_\_\_\_ Aborted: \_\_\_\_\_  
Premature: \_\_\_\_\_ Miscarriage: \_\_\_\_\_ C-Section: \_\_\_\_\_  
Number of living children: \_\_\_\_\_  
How do you currently prevent pregnancy? \_\_\_\_\_  
Have you ever used birth control pills before? \_\_\_\_\_

**Menstrual History:** Last menstrual period: \_\_\_\_\_  
Age you started your period: \_\_\_\_\_  
Number of days of flow: \_\_\_\_\_  
Do you have cramps with your period? \_\_\_\_\_  
Do you have problems with premenstrual tension or other period problems? \_\_\_\_\_  
Your period starts every \_\_\_\_\_ days.

**Patient Past History:** Allergies: \_\_\_\_\_  
Current Medications: \_\_\_\_\_

|                             |       |                                  |       |
|-----------------------------|-------|----------------------------------|-------|
| Do you smoke?               | _____ | If yes, number of packs a day?   | _____ |
| Have you ever had cystitis? | _____ | Blood transfusion?               | _____ |
| Asthma?                     | _____ | Kidney or bladder problems?      | _____ |
| Anemia?                     | _____ | Heart problems?                  | _____ |
| Hepatitis?                  | _____ | Aneurysm?                        | _____ |
| Jaundice?                   | _____ | High blood Pressure?             | _____ |
| Pneumonia?                  | _____ | Abnormal pap smear or dysplasia? | _____ |
| Tuberculosis                | _____ | If yes date: _____               | _____ |
| If yes, date: _____         |       |                                  |       |
| Dates of treatment : _____  |       |                                  |       |

**Previous Operations:** \_\_\_\_\_  
Type Date Physician

\_\_\_\_\_  
Type Date Physician

**Family History:** Mother: Age: \_\_\_\_\_ Health: \_\_\_\_\_  
Father: Age: \_\_\_\_\_ Health: \_\_\_\_\_  
Sister(s): Age: \_\_\_\_\_ Health: \_\_\_\_\_  
Age: \_\_\_\_\_ Health: \_\_\_\_\_  
Brother(s): Age: \_\_\_\_\_ Health: \_\_\_\_\_  
Age: \_\_\_\_\_ Health: \_\_\_\_\_

**Circle if anyone in your family has had or now has:**

|               |                 |                      |                |
|---------------|-----------------|----------------------|----------------|
| Diabetes      | Birth defects   | Heart disease        | Osteoporosis   |
| Depression    | Thyroid Disease | Elevated cholesterol | Ovarian cancer |
| Breast cancer | Kidney problems | High blood pressure  | Aneurysm       |
| Tuberculosis  |                 |                      |                |

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please print your name here

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Date

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED  
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on Jan. 1, 2008, and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Linda McDonald. Information on contacting us can be found at the end of this Notice.

### TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to voicemail messages, postcards or letters.

## YOUR PRIVACY RIGHTS AS OUR PATIENT

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be made at no charge to you. If you prefer a summary or an explanation of your health information, we will provide it for you.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (*Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.*)

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

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## QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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## HOW TO CONTACT US

**Practice Name:** Women's Health Group of Southeast Georgia

**Privacy Officer:** Linda McDonald, R.T.(R)(M)CDT

**Telephone:** (912) 267-0884

**Fax:** (912) 267-7948

**E-Mail:** whg@whgobgyn.com

**Address:** 3300 Fourth Street, Brunswick, GA 31520

HIPAA Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state law.

# Women's Health Group

## PRIVACY NOTICE AGREEMENT

I acknowledge that Women's Health Group of Southeast Georgia has provided me with a copy of its Notice of Privacy practices. I understand this acknowledgement means only that I have received the notice, and in no way effects the care I receive. I understand that Women's Health Group of Southeast Georgia will be in violation of HIPAA regulations should my medical record information be released without my written consent.

## FINANCIAL POLICY

I understand that in consideration of the services provided, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered by Women's Health Group. I am responsible for any applicable deductible or co-payments prior to the provision of services.

Women's Health Group of Southeast Georgia may file a claim for payment with my insurance company as required by contractual agreement. If the insurance company fails to pay Women's Health Group in a timely manner, I understand that I will be responsible for prompt payment of all amounts owed to Women's Health Group. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

## RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is my responsibility to provide Women's Health Group with a copy of my current insurance card and to obtain a referral from my primary care physician (PCP) if required by my insurance. Women's Health Group is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered Private Pay or Self Pay and will be financially responsible for the total amount of the services provided. I will notify Women's Health Group immediately upon any change to my insurance.

## INSURANCE WAIVER AND NON-COVERED SERVICES WAIVER Non covered service: \_\_\_\_\_

I understand that if I do not have a copy of a current insurance card and a valid referral, if required, Women's Health Group of Southeast Georgia is not obligated to see me, but if I still wish to be seen, I can be seen as a "Private Pay" patient. I agree that neither Women's Health Group nor I will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested or provided, that is not covered under my insurance plan ("non-covered services"). I understand I must pay for "non-covered" services. If feasible, a waiver will be completed for each "Private Pay" visit or "non-covered service". Initial: \_\_\_\_\_

## ANNUAL EXAMS

Annual (well woman) exams are preventative visits and are not paid for by all insurance carriers. I understand I am responsible for payment, if the exam or portion of the exam is not covered by my insurance. Annual exams do not typically include problems I may be having, as problem visits require longer times. If I am experiencing problems, the office may be required to reschedule another visit to the address these concerns.

## LAB SERVICES

All laboratory tests including pap smears and pathology will be billed separately, you may or may not receive a statement / bill for these services depending on your insurance carrier. We are unable to guarantee payment of lab services by your insurance carrier. Please contact your insurance company prior to having labs drawn should you have concerns regarding insurance coverage.

## ADDITIONAL INFORMATION

Women's Health Group accepts payments in cash, checks, and credit cards. I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account, and collection agency fees. In the event I receive a payment from my insurance carrier, I agree to endorse any payment due for services rendered to Women's Health Group.

## ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered directly to Women's Health Group. I hereby authorize Women's Health Group to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

## SIGNATURE

By signing this agreement, I acknowledge that I have carefully read, understand, and agree to the above terms and conditions.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT, GUARDIAN, OR LEGAL REPRESENTATIVE: \_\_\_\_\_ DATE: \_\_\_\_\_  
Signature

Employee who reviewed intake of form: \_\_\_\_\_ DATE: \_\_\_\_\_  
Signature

Women's Health Group of SE Georgia  
3300 Fourth Street  
Brunswick, GA 31520  
912-267-0884

**Consent to Use or Disclose Information for Treatment, Payment or Healthcare Operations**

I the patient (or authorized representative) consent Women's Health Group to the use or disclosure of my individually identifiable "protected health information" for the purpose of treatment, payment or healthcare operations as the terms are defined under federal HIPAA privacy rules.

My "protected healthcare information" means health information collected from me or my representative and created or received by my health care provider, another healthcare provider, insurance carrier, my employer or a health care clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have the right to revoke this Consent. Such revocation must be submitted to Women's Health Group in writing. The revocation shall be effective except to the extent that Women's Health Group has already taken action in reliance on the Consent.

I have received or have been allowed to view a copy of Women's Health Group's "Notice of Privacy Practices" as required by HIPAA.

**I authorize discussion of my general medical condition and diagnosis (including treatment, payment, and healthcare options) with: (If no one, leave blank)**

| <b>Name: (Please Print)</b> | <b>Phone #</b> | <b>Relationship</b> |
|-----------------------------|----------------|---------------------|
| _____                       | _____          | _____               |
| _____                       | _____          | _____               |
| _____                       | _____          | _____               |

Can we leave a message on your answering machine or voice mail concerning lab or test results? I (the patient) understand that answering machines and cell phones are not secure lines. Yes \_\_\_\_\_ No \_\_\_\_\_

I understand that Women's Health Group may send letters, postcards or leave voice mail messages for appointment reminders and mail billing statements to the Guarantor on my account.

I certify that I am the patient (or authorized representative) and that the information given by me to the Provider in applying for payment under Medicare and/or Medicaid programs, insurance plans, or other protection is correct and complete. I understand, acknowledge and agree to the terms set forth above.

|  |                        |   |
|--|------------------------|---|
| _____<br>Signature of Patient                | _____<br>Date          | <b>Security Question<br/>(Circle 1)</b> |
| _____<br>Please Print Name                   | _____<br>Date of Birth | 1. Mother's Maiden Name?                |
| _____<br>Authorized Representative Signature | _____<br>Date          | 2. Favorite Color?                      |
| _____<br>Please Print Name                   |                        | 3. Favorite Pet's Name?                 |
|  |                        | 4. City you were born?                  |
|  |                        | <b>Answer:</b> _____                    |

You will be asked your Security Question when you call our office requesting either account or records information.