

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

Dear Patient,

Please complete the enclosed forms to update for 2010 and return them to our office prior to your appointment. If there is not adequate time to mail the forms, you may:

- Bring the forms with you to your appointment
- Fax to 912-267-6537
- E- mail to scheduling@whgobgyn.com

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 Norvell, MD
John Ellenberg, MD
Matthew Johnston, MD
Tina Mitchell, MD

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 _____

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

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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)

Name: (Please Print)	Phone #	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.

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

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