East Georgia Women's Center, P.C.

REFERRED BY: _______________

1. PATIENT DEMOGRAPHIC INFORMATION

LAST NAME	FIRST NAME	MI	HOME PHONE #	CELL PHONE #
STREET ADDRESS			WORK PHONE #	
MAILING ADDRESS			PHARMACY	
CITY	STATE	ZIP CODE	SOCIAL SECURITY#	
BIRTHDATE	AGE	MARITAL STATUS	RACE / ETHNIC GROUP	E-MAIL ADDRESS
EMPLOYER		OCCUPATION	REFERRING / FAMILY PHYSICIAN	

2. SPOUSES INFORMATION

NAME	BIRTHDATE	SOCIAL SECURITY #
SPOUSE'S OCCUPATION	SPOUSE'S EMPLOYER	WORK PHONE #

3. PARENT/GUARDIAN INFORMATION

NAME	BIRTHDATE	RELATION
ADDRESS		
EMPLOYER	WORK PHONE #	HOME PHONE #

4. NEAREST RELATIVE (not living with you)

LAST NAME	FIRST NAME		MI	RELATION
ADDRESS	CITY	STATE	ZIP CODE	PHONE #
IN CASE OF EMERGENCY CONTACT				PHONE #

5. INDIVIDUAL RESPONSIBLE FOR BILL

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR MY MEDICAL BILLS

SIGNATURE

ASSIGNMENTS OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to East Georgia Women's Center, P.C. for the services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize East Georgia Women's Center, P.C. to release to my insurance company any information required, including diagnosis and records of my examination and treatment, by any means including FAX. A copy of this authorization may be used in lieu of this original.

MEDICARE / MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

PATIENT SIGNATURE	DATE
PARENT / GUARDIAN (please print)	SIGNATURE

Presentation of your Insurance card is required prior to each office visit.
It is our policy that payments and co-payments are due at each time of service.

East Georgia Women's Center, P.C

1.) Please list any family members or other persons whom we may release information concerning your medical record.

Name________________________ Phone# ________________________

Name________________________ Phone# ________________________

2.) Please list the telephone number where you want to receive calls about your appointments, lab results, X-ray results, or other health care information.

____

3.) Emergency Contact

Name:_________________ Home#______________ Cell#________________

PATIENT NAME: ________________________ (Guardian if under age 18)

PATIENT/GUARDIAN SIGNATURE:_____________________ DATE:______________

WITNESS:_____________________________ DATE: _____________

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I, ______________________________, understand that as part of my health care, East Georgia Women's Center, P.C. originates and maintains paper and or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and lay plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communications among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a <u>*Notice of Privacy Policies*</u> that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that East Georgia Women's Center, P.C. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sing this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that East Georgia Women's Center, P.C.

I further understand that East Georgia Women's Center, P.C. reserves the right to change their notice and practice and prior implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should East Georgia Women's Center, P.C. change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosures of my health information:

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

____
Patient Signature

____
Date