PATIENT INFORMATION

Patients Last Name: _____ First Name _____ Date:_____

S.S. # _____ - _____ - _____Driver's Lic # _____

Address:_____ City : _____ State: _____ Zip:_____

Mailing address (if different than above) _____

E-mail Address: _____ (NEEDED FOR INVITE TO PATIENT PORTAL)

DOB: _____ Age: _____ Marital Status: Single Married Widowed Race: _____

Home Telephone #: (____)_____Cellular # : (____)_____

Employed by: _____Occupation: _____

Business Address: _____Work Telephone # :(____)_____ext. _____

City: _____State: _____ Zip_____

EMERGENCY NOTIFICATION

Name: _____Relation:_____

Address:_____ Phone: _____

(Must be completely filled) **PRIMARY INSURANCE INFORMATION**

Insurance Company:_____

Address of Insurance: _____

City: _____ State: _____ Zip Code: _____ Phone # (_____)_____

Person on Insurance Policy: _____ _____

Relation to patient _____ Date of birth: __________ S.S. #: _____ - _____ - _____

Address (if different from patient's) _____

Person responsible employed by _____

Business address and phone number _____

Insurance ID number: _____ Group name or number: _____

Is patient covered by additional insurance? _____ Yes _____ No

If yes, please list _____

Referred By: ☐ Yellow Page ☐ Bench Ads ☐ Friend ☐ Other: _____

AUTHORIZATION OF PAYMENT

All professional services are charged to the patient. The patient is responsible for all fees incurred, regardless of insurance coverage. It is understood that payment for services rendered are paid at the time I sign in.

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Sun City Women's Health Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and it is my responsibility. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

_____ _____ _____

SIGNATURE Date Relationship

We want you to receive the very best care possible and be totally satisfied with our services. To do this, Sun City Women's Health Care providers will gladly discuss your proposed treatment and answer any questions you have. Our friendly and experienced staff will also be happy to answer any questions regarding your account. Here are some important points to remember regarding your care through this office.

1. To keep medical care and billing cost down, **payment is due at time of service** unless a payment plan has been approved in advance IN WRITING by our billing department and the credit card authorization form has been completed and signed. It is the patient's responsibility to bring a current insurance card to every appointment.

2. We are contracted providers for Medicaid and most private insurance plans. In those cases, we have agreed to accept their determination of fees for covered services. As a courtesy to our patients, Sun City Women's Health Care submits claims to primary insurance carriers. You will still be responsible for the payment of deductibles, co-payments and non-covered services. These payments are due at the time of service. If you have a secondary insurance we will submit the claims to your insurance. If you are pending secondary insurance you're responsible for any deductibles or co-payment at the time of service is rendered. We will not reimburse any payments, if the insurance retro actives your dates of eligibility .

3. Not all services are a "covered" benefit in all insurance policies. Your policy is a contract between you and your insurance company. We are not a party to that contract. Although we will call and attempt to verify benefits and coverage, we cannot determine the benefits of your insurance policy. Verification of benefits is not a guarantee of payment. Payment for these services is the responsibility of the patient. We strongly encourage you to carefully read your insurance policy so that you will know the conditions and circumstances of the coverage that is available to you. Our accepting assignment does not relieve you of your personal responsibility for the prompt payment of the total bill. If your insurance does not completely or promptly pay, you are responsible for calling your insurance company immediately upon receipt of a bill showing charges denied by your insurance.

4. If you choose not to complete the credit card authorization form, your balances will be placed on a billing cycle. After three cycles or 60 days, unpaid balances will be referred to a collection agency.

5. Our staff can answer many questions over the phone and when necessary the Physicians / Physician Assistant / Women's Health Practioner will call you back at a convenient break. However, telephone calls used in lieu of an office visit will be billed accordingly. We engorge you to use the patient portal for non urgent messages.

6. You may be charged for appointments broken or cancelled without a 24 hours advance notice. Surgical or Sono appointments broken or cancelled without a 48 hours advance notice will be subject to a surgical set up fee. Your insurance carrier does not cover these fees. Appointments after 5:30 are considered after hour services. This additional charge will be included on your visit which is billed to your insurance.

7. I agree to pay $15 to have the staff at Sun City Women's Health Care, fill out any forms for either my spouse or myself. This includes Family Medical Leave Act Forms, Insurance Forms Disability Forms and any other forms required by my Employer, School, or Government Agency.
   Initial _____

8. If your diagnosis or treatment involves others: such as hospital or laboratories, you will be billed by these entities separately. You are responsible for payment of their bills. You should make your own financial arrangements with these care providers.

I / We authorize Sun City Women's Health Care and Staff of Sun City Women's Health Care to treat the patient named on this form and agree to pay all fees and charges for such treatment. I / We agree to pay all charges for myself or members of my family per the terms of this agreement. Charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days.

_____ _____

NAME OF PATIENT SIGNATURE OF PATIENT/GUARDIAN DATE

I consent to the use or disclosure of my protected health information by Sun City Women's Health Care for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Sun City Women's Health Care.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Sun City Women's Health Care is not required to agree to the restrictions that I may request.

I have the right to revoke this consent, in writing, at any time, except to the extent that any provider at Sun City Women's Health Care has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This 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 understand I have a right to review Sun City Women's Health Care's Notice of Privacy Practices prior to signing this document. The Sun City Women's Health Care's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Sun City Women's Health Care. The Notice of Privacy Practices for Sun City Women's Health Care is also provided at the front reception desk and on the Sun City Women's Health Care's website at www.suncitywomenshc.com This Notice of Privacy Practices also describes my rights and the Sun City Women's Health Care's duties with respect to my protected health information.

The Sun City Women's Health Care facility reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Sun City Women's Health Care's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

MUST SIGN

Sun City Women's Health Care
OBSTETRICS AND GYNECOLOGY

PRIVATE PAY AGREEMENT

I understand Sun City Women's Health Care office / Physicians / Physician Assistant / Women's Health Nurse Practioner is accepting me as a patient with commercial or Medicaid insurance. I am aware that I will be responsible for any portion not covered by my insurance plan. Sun City Women's Health Care will not file any retroactive claims to Medicaid if I become eligible. Secondary insurance are accepted and the claim will be submit for payment to Medicaid or secondary commercial insurance. This pertains only to OB.

Signed by: _____ Date: _____

CONTRATO DE ASEGURANZA COMERCIAL

Yo entiendo que Sun City Women's Health Care office or Dr. Michiel R. Noe, . me esta aceptando como paciente con aseguranza comercial o Medicaid. Yo acepto que soy responsable por cualquier porcion no cubierta por mi plan de aseguranza. Sun City Women's Health Care, no procesara ningun reclamo retroactivo a Medicaid si llego a ser elegible. El seguro secundario es aceptado y el reclamo será se somete para el pago a Medicaid o el seguro comercial secundario.

Firma: _____ Fecha: _____

Must Sign

Sun City Women's Health Care
OBSTETRICS AND GYNECOLOGY

Non-Covered Charges

I _____ fully understand and agree that as a condition of being accepted as a patient of Sun City Women's Health Care, I accept all responsibility in paying all charges, in full, that are not covered by my insurance. I have been informed that certain charges are rarely covered by insurance and as such I do not expect my insurance to be billed for them. Instead, I agree to accept responsibility for those payments myself, in full and in a timely manner. Charges that are not covered by my insurance, that I expect to be billed for and agree to pay in full include but are not limited to:

- Failed Appointments: I agree to pay $20 for each appointment that I make with Sun City Women's Health Care if I fail to show up for the appointment on time or reschedule the appointment without 24 hr notice. *This charge will be waived if I give 24-hour notice of cancellation.*

- Filling Out Forms: I agree to be billed and pay $15 to have the staff at Sun City Women's Health Care fill out any forms for either my spouse or myself. This includes Family Medical Leave Act Forms, Insurance Forms, Disability Forms and any other forms required by my Employer, School, or Government Agency.

- Lost prenatal cards will be replaced for a fee of $5

- Fertility: Office visits, procedures and follow-up appointments for infertility patients will be billed to me. Payment is expected at time of service. I understand that I may bill my insurance if I wish.

- Ultrasounds: I agree to pay for any ultrasounds that are not covered by my insurance (applies primarily to AETNA patients). I understand that I will be liable for paying the balance in full at the time of service. I understand that I can decline the ultrasound to avoid any financial responsibility. I also understand ultrasound videos are not covered by any insurance, if I choose to purchase a video I am responsible for all charges.

I understand that other services, procedures and treatments may be provided to me at Sun City Women's Health Care and that any services not covered by my insurance carrier will be my responsibility to pay in full and in a timely manner.

_____ _____

Signature Date Witness Date

(Notice of Privacy Practices)

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

In the course of your care as a patient at *Sun City Women's Health Care*, we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, inclusive of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intent for us to provide care.
*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to

request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may not longer be protected by the federal privacy rules.

If you have a complaint or would like further information regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, please contact: the Office Manager

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This notice is effective as of November 22, 2002. This notice, and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Printed please)	Signature	Date

If you are a minor, or if you are being represented by another party:

_____	_____	_____
Personal Representative (Printed)	Personal Representative Signature	Date

_____

Description of the authority to act on behalf of the patient.

Sun City Women's Health Care
OBSTETRICS AND GYNECOLOGY
1440 George Dieter Dr.
El Paso, Texas 79936

Physician Assistant
&
Women's Advance Practice Nurse

This facility has on staff an Physician Assistant and/or Advance Practice Nurse to assist in the delivery of medical care (Physician Assistant & Women's Nurse Practitioner).

A Physician Assistant and/or Advance Practice Nurse is not a doctor.

A Physician Assistant is a healthcare professional who is trained to practice medicine. Physician Assistant practice medicine as a team and exercise a scope of practice and knowledge content similar to their supervising physician. Physician Assistant can diagnose, treat, and monitor common acute and chronic diseased as well as provide health maintenance care. In addition, the Physician Assistant may treat minor lacerations and other minor injuries.

An advance practice nurse is a register nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat, and monitor common acute and chronic diseased as well as provide health maintenance care.

I have read the above, and hereby consent to the services of an Physician Assistant and/or Advance Practice Nurse for my health care needs.

There are will be sometime when you will be scheduled with an Physician Assistant and/or Advance Practice Nurse, due to the physician called out to a delivery, family emergency or any other circumstances. I understand that at any time I can refuse to see the Physician Assistant /Advance Practice Nurse and request to see a physician. At that time your appointment will be rescheduled for an available time slot with the physician.

Name:	Date:
Signature:	Witness: (optional)