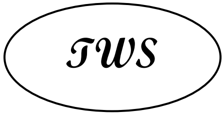

Tacoma Women's Specialists, PS
Obstetrics, Gynecology and Infertility

John P. Lenihan Jr., M.D.
Clare L. Cammarano, M.D.
Carol J. Kovanda, M.D.
Donald A. Boutry, M.D.
Terry M. Silvestrin, A.R.N.P.
Shauna R. Weatherby, A.R.N.P.

Patient Information

Date_____/_______/_______

Patient Name____
Last *First* *M.I.*

Marital Status: _____ Married _____ Single_____ Other Date of Birth_____/_______/_______

Social Security Number________-______-__________

Patient Address____
Street *City* *State* *Zip Code*

Primary Phone (_____)_________________________ Home__ Cellular__ Work__ May leave detailed message __

Secondary Phone (_____)_______________________Home__ Cellular__ Work__ May leave detailed message __

E-mail Address_____________________________________

Employer____ Occupation________________________________

Partner's Name_____________________________________ May leave personal health Information__

Partner's Phone (_____)______________________________ Home__ Cellular__ Work__

Emergency Contact (person not living at same address)

Name_________________________________ Relation __________________ Phone (____)___________________

Primary Care Physician:___________________________Phone:____

INSURANCE INFORMATION:

In order to bill your insurance(s) we must have a copy of your insurance card(s) presented at each visit.

Insurance Company, Name and Address____

Group #_________________________ Identification #____ __

Is patient the subscriber? Yes___ No___ If no, then: Subscriber's Name_____________________________________ __

Subscriber's Soc Sec #___________________________________ Subscriber's Date of Birth ______/______/_______

Subscriber's Employer ____________________________________ Relationship to Patient ______________________

Secondary Insurance Company, Name and Address____

Group #_________________________ Identification #____ _

Is patient the subscriber? Yes___ No___ If no, then: Subscriber's Name_____________________________________ _

Subscriber's Soc Sec #___________________________________ Subscriber's Date of Birth ______/______/_______ _

Subscriber's Employer_____________________________________ Relationship to Patient _____________________

(please turn over)

PATIENT CONSENT & RELEASE

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to Tacoma Women's Specialists, PS. I authorize the release of any information required to process my claim. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to collections I will be responsible for all collection fees, collection costs, attorney fees and court costs involved with my account. **Initial** _________

FINANCIAL POLICY

Our office is committed to providing quality and cost-effective healthcare to our patients. In today's insurance environment it is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorizations or referrals prior to your appointment with us. It is your responsibility to understand the limits and restrictions affecting coverage for services provided by our specialty. If your insurance company requires you to use a specific lab, it is your responsibility to notify us. Insurance reimbursement is a contract between you and your insurance company. As a courtesy to you we will file all primary and secondary claims for you. We will require a current copy of your insurance card in order to do this and will need to be informed of any change in insurance status. You will be responsible for all co-pay, deductibles, and co-insurance amounts not covered by a secondary insurance policy along with the entire amount of any non-covered service. We appreciate payment for services at the time they are rendered. For your convenience, we accept cash, personal checks, Visa, MasterCard and Discover. If your personal check is returned by the bank due to *Insufficient Funds,* a fee will be charged. We also realize that healthcare is sometime an unplanned event, so we will attempt to accommodate your personal needs as circumstances require. Patient who do not have insurance coverage (or proof of coverage) or who choose to pay for non-covered service are expected to pay in full at the time of service. If you cannot pay the full amount then you may be able to make payment arrangements with our business office prior to receiving services. We charge for the completion of FMLA and Disability forms. In order to best meet your needs, please call our business office at (253) 272-5572 with any questions you may have regarding our financial policy and procedures. **Initial** _________

PREVENTIVE CARE

Your health insurance plan may not provide coverage for preventive services. It is important that you contact your insurance provider to determine if your plan offers benefits for this service and what their scheduling guidelines are for it. We use industry standard codes and guidelines to submit claims to the insurance companies based on the primary focus of the exam and documentation in the patient's medical record. Current laws regarding fraud and abuse with billing procedures prohibit us from changing the procedure codes and/or diagnosis codes in order to get the claim paid by the insurance company. DSHS does not pay for annual exams, payment is your responsibility. **Initial** _________

NOTICE OF INFORMATION PRACTICES – ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You have the right to know how we use and disclose information about you. This is provided in our *Notice of Health Information Practices.* You may also ask to see and copy your records. If you would like more information, please call and ask for our Medical Records Department. **Initial** _________

PRESCRIPTION REFILL POLICY

Please allow 2 business days for completing prescription refill requests. When calling on a Friday, the request will not be completed until Monday. Please note that on call Physicians do not refill medications or prescribe narcotics over the phone.**Initial** _______

ACKNOWLEDGEMENT OF RECEIPT/OFFER OF NOTICE OF PRIVACY PRACTICES

Dear Patient:

Federal law requires us to provide you with a Notice of Privacy Practices, which is our explanation of how we use and disclose your health information, and to ask you to acknowledge that you have received the Notice.

You have the right to review our notice before signing this acknowledgement, and, if you have any questions, to ask for an explanation of any part of the Notice, or any other aspects of our use and disclosure of your health information. The terms of our Notice may change as the law and our practices change. If we change our Notice, we will have revised copies available to you when you visit us, and also send you a revised copy upon your request.

We appreciate you signing this form, which acknowledges that you have received, or have been offered and refused, a copy of our Notice.

Persons authorized to receive protected healthcare information:ie, spouse, friend, etc.

1.____

2.____

3.____

Initial_______

I have read and understand the above policies.

Patient Signature ____ Date:______________________________

(or legally authorized individual's signature)

Printed Name if signed on behalf of patient _________________________________ Relationship ________________________