

Account # _____ Appt. Date _____ Provider: CD / LH Verified By: _____

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **M.I.:** _____

Address: _____ **Nickname:** _____

City: _____ **ST:** _____ **ZIP:** _____ **Phone:** _____ **Cell:** _____

SSN: _____ **DOB:** _____ **Marital Status:** S M Sep D W

Employer: _____ **Phone:** _____ **Ext:** _____

Address: _____ **Occupation:** _____

City: _____ **ST:** _____ **ZIP:** _____ **Email address:** _____

Referred by: _____

Primary Care Doctor: _____

SUBSCRIBER INFORMATION

Policy Holder Name: _____ **Relationship to Insured:** _____

Address: _____

City: _____ **ST:** _____ **ZIP:** _____ **Cell:** _____

SSN: _____ **DOB:** _____ **Age:** _____

Employer: _____ **Occupation:** _____

Address: _____ **Phone:** _____ **Ext:** _____

City: _____ **ST:** _____ **ZIP:** _____

INSURANCE INFORMATION

Individual Policy

Employer Group Policy

Primary Insurance Company Name: _____

Claims Mailing Address: _____

City: _____ **ST:** _____ **ZIP:** _____ **Customer Service Phone:#:** _____

Subscriber/Member ID#: _____ **Group/Account#:** _____

Secondary Insurance Company Name: _____

Claims Mailing Address: _____

City: _____ **ST:** _____ **ZIP:** _____ **Phone:** _____

Subscriber/Member ID#: _____ **Group/Account#:** _____

Name, Address, and Phone of Friend/Relative not living with you: _____

I authorize any physician or hospital that has treated me in the past to release a copy of my medical records to Devoted to Women, PA. This shall specifically include information relating to psychiatric conditions, alcohol and/or drug abuse, and HIV testing results. I authorize Devoted to Women, PA to release any information contained in my medical record to my insurance company or another physician. This shall specifically include information relating to psychiatric conditions, alcohol and/or drug abuse, and HIV testing results. I authorize and instruct my insurance company(s) to pay all benefits and payments directly to Devoted to Women, PA. I understand that I am financially responsible for my account regardless of my insurance payments or benefits.

Signed: _____ Date: _____

Please allow us to make photocopies of your insurance card(s) and driver's license. This information will help us communicate more effectively with you and your insurance company. Thank you for your assistance and cooperation.

Devoted to Women, P.A.

Patient Authorization for Use and Disclosure
Of Protected Health Information

Patient Name: _____

Date of Birth: _____ Social Security #: _____

By signing this authorization, I authorize *Devoted to Women, P.A.* to *obtain / release* (please circle that which applies) certain protected health information (PHI) about me from/to:

(Name and address of entity being asked to release information or the entity to which the information will be forwarded)

The information requested to be obtained from the entity listed above should be sent to:

Devoted to Women, P.A.
661 E. Altamonte Drive, Suite 224
Altamonte Springs, FL 32701
Phone: 407-830-9000 Fax: 407-830-9040

This authorization permits the following individually identifiable health information about me to be obtained/released:

- My complete medical record
- Visit services provided by only the following physicians(s) or other practitioner(s) _____

- Office/Outpatient/Inpatient Diagnostic Testing
- Alcohol and/or drug abuse
- Operative reports for invasive/surgical services
- Medication Lists
- HIV testing/diagnosis
- Other _____
- Laboratory Results

The information will be used or disclosed for the following purpose: (check one)

- My records only
- Transferring Care to _____
- I am moving out of area.

My new address is: _____

Signed: _____ Today's Date: _____
Signature of Patient

Signed by Personal Representative/Guardian
(if applicable)

Print Personal Representative/Guardian Name Relationship to Patient

For Internal Purposes Only

Completed by: _____ Date completed: _____

- Fax
- Pick-up
- Mailed
- Other

Devoted to Women, P.A.
661 E. Altamonte Drive, Suite 224
Altamonte Springs, FL 32701
Phone: 407-830-9000 Fax 407-830-9040

COMMUNICATION
USE AND DISCLOSURE AUTHORIZATION

Please complete the following information for all requests

1. Today's Date: _____
2. Patient Name: _____
3. Date of Birth: _____ 4. SS# _____

I hereby request the following regarding the use of my *PERSONAL HEALTH INFORMATION*:

1. You may leave the following messages on my work/home/cell (circle one) voice mail:

- Referral Information
 Prescription Refill Information
 Test Results
 Appointment Reminder Information
 Other: _____

2. You may discuss information regarding my treatment and care with the following family members and/or friends:

3. You may contact me regarding my treatment and care at the following numbers:

I have read and understand the Notice of Privacy Practice and the information in this disclosure.
By signing below, I acknowledge and agree to the above conditions.

Signature of Patient or Guardian

Print Name of Patient or Guardian

Witness/Signature of DTW Staff

Title of DTW Staff

FINANCIAL POLICY

*****Please Read Thoroughly and Sign Below*****

Thank you for choosing Devoted to Women, P.A., as your health care provider. Because of the many changes in insurance companies we are requesting that our patients sign this Financial Policy confirming that their insurance company has not changed from their prior visit, if applicable, and that we have been provided the **correct** insurance information for billing purposes.

Today we are filing _____ Insurance Company

It is also your responsibility to know what laboratory your insurance company is contracted with and where your lab work should be sent. Please **circle and initial** the lab below that participates with your insurance plan.

Quest Diagnostics

Florida Pathology

Labcorp

Please understand that it is the patient's responsibility to know the rules and regulations of their policy. Upon check-in, we will collect your co-pay, deductible, co-insurance and any non-covered service that we have verified to be your responsibility. If we are not a participating physician, you will become responsible for today's visit. It is our policy to reschedule any patient unable to pay prior to seeing the provider unless prior financial arrangements have been made with our office manager, Allison Kern.

Our office will not fraudulently change a diagnosis in order for services to be covered by your insurance plan. If your insurance company denies our charge as a non-covered benefit, you will be expected to pay in full for your services within 30 days.

If your service remains unpaid by your insurance company after 45 days, you need to call your insurance company to check the status of the claim and then contact our billing department to assist you, if necessary. If payment is not received by you within a timely manner, your account may be turned over to collections.

We accept Visa, MasterCard, cash and local personal checks with valid picture ID. All returned checks are subject to a \$30 fee. All forms to be completed for "Time off" (i.e., FMLA, disability form, attending physician's statement) are subject to a \$20 per form for administrative fee.

I understand that I am fully responsible for services rendered here at Devoted to Women.

Signature of Patient or Guardian

Date

Print Name of Patient or Guardian

Witness/Signature of DTW Staff

Date

Title of DTW Staff*

Devoted to Women

661 E Altamonte Drive * Suite 224 * Altamonte Springs, FL 32701 * (407)830-9000