Dominion Women's Health, Inc.

Patient Information

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

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone:(Cell) _____ Phone: (Home/Work) _____

Date of Birth: _____ Social Security No.: _____ Gender Identity: _____

Preferred Language: _____ Race/ Ethnicity: _____ Sexual Orientation: _____

Email: _____ **Preferred contact by:** Patient Portal Phone Mail

In case of emergency, contact: _____ Relationship: _____

Phone (Cell & Alternate #): _____

Were you referred by another doctor? YES ☐ NO ☐ Do you have a Primary Care Doctor? YES ☐ NO ☐

Doctor's Name: _____ PCP Name: _____

Doctor's Phone: _____ PCP Phone: _____

Insurance

Do you have medical insurance? YES ☐ NO ☐ Insurance Name: _____

Is this insurance through your employer? YES ☐ NO ☐ Are you the subscriber to this policy? YES ☐ NO ☐

Insurance Address: _____

Policy ID #: _____ Group #: _____

Subscriber Name: _____ Relationship: _____

Subscriber SSN: _____ Subscriber Date Of Birth: _____

Do you have another medical insurance? YES ☐ NO ☐ Insurance Name: _____

Are you the subscriber to this policy? YES ☐ NO ☐

Insurance Address: _____

Policy ID #: _____ Group #: _____

Subscriber Name: _____ Relationship: _____

Subscriber SSN: _____ Subscriber Date Of Birth: _____

Patient Policies

Thank you for choosing Dominion Women's Health, Inc. as your health care provider. We are committed to building a successful physician-patient relationship with you. Please understand that payment for services is a part of that relationship. The following is a statement of our Office Policies, which we require you to read and sign prior to treatment.

Patient information
Patient's information will be updated yearly. A signature by the patient and/or legally responsible party is required. If there is a change of residence, phone number or insurance information, it is the responsibility of the patient or patient's legally authorized representative to notify us of the change.

Insurance claims
Our office will file claims with the patient's insurance for anticipated covered services, excluding bio-identical hormone replacement therapy. It is the patient's responsibility to determine if Dominion Women's Health, Inc. is a contracted, in-network provider for your specific insurance plan. In the event the patient has insurance coverage but Dominion Women's Health is unable to verify you have active coverage, the patient will be considered self-pay and payment is due at the time of service. Upon verification of an active insurance, we will submit claims to the insurance company at that time. **Coverage is not a guarantee of payment and the patient/ guarantor is responsible for all charges not covered by your insurance.**

Authorizations
Our staff will obtain any necessary Pre-certification or Pre-authorization for surgery or any other procedure, and/or testing. It is the patient's responsibility to notify Dominion Women's Health, Inc. of any changes to your insurance prior to any surgery or procedure. Dominion Women's Health, Inc. will not be responsible for any charges incurred as a result of failure to obtain authorization as a result of a patient's failure to advise Dominion Women's Health, Inc. of other health insurance.

Affiliated Organizations
Some services require testing through independent labs such as: LabCorp, Greensborough Pathology, Myriad, NTD labs, etc. Depending on your insurance coverage, you may receive bills from these labs. If your insurance requires a specific lab to be used, it is your (the patient) responsibility to notify the nurse before the end of your visit.

Patient Financial Responsibility
Co-payments, deductibles, co-insurance and any medical services not covered by an individual's insurance plan are the patient's responsibility and are **DUE AT TIME OF SERVICE.**

If you do not have insurance coverage, all services **PRIOR TO SERVICES RENDERED** must be paid prior to services being rendered. Should you require surgery, the provider's surgical fees must be paid prior to having surgery.

Physicians **DO NOT** discuss any financial issues. Our billing staff is trained to discuss your account and will be happy to help you. If the billing representative is not able to completely assist you, our Billing Manager or Administrator can be consulted as well.

The billing department makes every effort to work with our patients to assist them with payment plans for outstanding balances, excluding balances that have been forwarded to collections. The billing department will set-up a monthly payment plan utilizing your credit card for automatic monthly payment and/or payment by check or cash.

We accept cash, checks, money orders, Debit, Visa, MasterCard, Discover Card and American Express.

Checks received "paid in full"
It is the policy of the practice not to accept checks marked "Paid in full" since there might be charges still pending with the insurance carrier.

Returned Check Policy
If a check is returned, a note will be made in the account that the specific check payment has been returned and the account is charged with the returned-check processing fee of $35.00. The patient is informed that the office will no longer accept a personal check as a method of payment.

The patient will be notified by mail that she has 5 days to present at the office with cash, money order, certified check or credit card; otherwise the check will be forwarded to the state's worthless check/fraud unit.

Patient Refunds
Refunds will not be issued until all charges have been cleared by your insurance for the visit for which you paid. For maternity payments, refunds will not be issued until after your post-partum visit and your insurance claims for all of your maternity visits have cleared. Refunds will only be released in person to an authorized patient representative or via mail.

Medical Records and Forms
If you require a copy of your record or a form to be completed, you must pay $15.00 prior to receiving the records or form. Legally we have 30 days after we receive written authorization from the patient to complete the form. Patients requesting FMLA, disability, work, and/or school forms to be completed MUST pay a $15.00 fee prior to the forms being completed and allow 5 to 7 business days to be completed.

I understand that in the event that I may need a printed copy of my medical records for any reason (transferring care, personal file, etc.); I will be required to pay a $15.00 fee. My payment will be due before my records will be processed and released. I also understand that there will be a 5 to 7 business day waiting period for my records to be released. Upon requesting a copy of my records, I will be required to complete and sign a Medical Records Release form. This form will grant Dominion Women's Health, Inc. permission to release my records, as per my request. In some circumstances, if records are requested to be sent directly to another doctor's office to continue your care, there will be no fee. Most medical records are available to you at no cost through the Dominion women's Health, Inc. patient portal. To request access or for additional assistance with the patient portal, please speak with a front desk representative.

I understand that I may ask any questions if I do not understand the Dominion Women's Health, Inc. Medical Records policy stated above.

Outstanding Balances
It is understood and agreed that the undersigned (jointly and separately if more than one) is liable for all charges incurred or to be incurred for any and all medical and/or surgical services rendered or to be rendered by or through Dominion Women's Health, Inc., in connection with the patient named herein. It is further understood and agreed that if medical or hospitalization insurance fails to promptly pay all such charges, the undersigned shall immediately pay the account in full. In any event of a past due balance, payment in full of any past due balance is expected prior to being seen in our office in the future.

The undersigned authorizes the payment of all insurance benefits to Dominion Women's Health, Inc., and authorizes Dominion Women's Health, Inc. to release any information required by any insurance carrier to secure such payment and as required by our contract with your insurance.

Dominion Women's Health, Inc. utilizes an outside collection agency to collect any outstanding balances which do not maintain an active/current payment status with the practice. Failure to uphold payment arrangements and/ or any un-paid balance for 90 days or more may result in attempt to collect by a designated Collection Agency. In the event your account is turned over to the Collection Agency, we will no longer be able to set-up payment plans. All collection account balances must be paid to the collection agency. In addition to the balance, a fee of thirty-three and one third percent (33 1/3%) of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other cost incurred directly or indirectly to collect amounts owed under this agreement (i.e. court costs, attorney fees, etc.)

If the undersigned fails to pay an account when due and the amount is referred to an attorney for collection, then the undersigned agrees to pay a collection fee of thirty-three and one third percent (33 1/3%) of the balance due and also attorney fees incurred by Dominion Women's Health, Inc. when applicable.

Bankruptcy
If Dominion Women's Health, Inc. is notified of a patient bankruptcy, the patient will be dismissed from our practice and no further appointments are made.

Appointment Policy - Failure to Show or Cancel
Dominion Women's Health, Inc. appreciates that everyone's time is valuable. For this reason, effective 5/1/16, a fee of $10 for Current Patients & $20 for New Patients will be charged for any appointment that is not canceled 24 hours prior to the appointment or a "No Show". This fee is due immediately upon occurrence.

Consent for HIV testing

In the event of exposure to my blood or bodily fluids by any Dominion Women's Health, Inc. staff or anyone interacting with my specimen, I consent for the HIV (Human Immunodeficiency Virus) blood test which may indicate the presence of acquired immunodeficiency syndrome (AIDS).

I understand that if I desire to have this test for HIV done for a reason other than related to an exposure incident, I must request it with my provider.

I have been informed and understand that the test results will not always predictably indicate that a person has AIDS, will develop AIDS, or is immune to AIDS; but that a positive test can be associated with the transmission of HIV to other persons.

I understand that the results of my HIV testing will become a part of my medical record. Further release of information will be done only with my written authorization.

The undersigned certifies that he/she has read and understands the foregoing, has had the opportunity to ask questions, and is the patient, or is the patient's legally authorized agent or representative.

Signature: _____ Date: _____

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have been provided the opportunity to receive & read a copy of Dominion Women's Health, Inc.'s Notice of Privacy Practices. I understand that I may ask questions to Dominion Women's Health, Inc. if I do not understand any information contained in the Notice of Privacy Practices.

Signature: _____ Date: _____

Disclaimer and Signature

I HAVE READ & UNDERSTAND ALL POLICIES SET FORTH BY DOMINION WOMEN'S HEALTH, INC., AND I AGREE TO THE TERMS OF THESE POLICIES. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF ANY OF THE POLICIES MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT NOTIFICATION TO THE PATIENT.

Patient
Signature: _____ Date: _____

Patient Name (Print):_____

Legal Guardian/ Representative Signature: _____ Date: _____

Legal Guardian/ Representative Name (Print): _____

Dominion Women's Health's witness: _____