Date:_____ Patient #: _____
(For office use only)

WOMAN'S GROUP OF MERIDIAN, PLLC

PATIENT INFORMATION

New Patient _____ **Update** _____

Patient Name: _____
Last *First* *Middle* *Maiden (if applicable)*

Prefix	*Date of Birth*	*Social Security Number*	*Gender*
Miss Mrs. Ms Mr.	/ /	— —	[ ] Female [ ] Male

MARITAL STATUS: [ ] Single [ ] Married [ ] Other _____

RACE: [ ] American Indian/Alaska Native [ ] Asian [ ] Black/African American [ ] White [ ] Other

ETHNICITY: [ ] Hispanic/Latino [ ] Not Hispanic/Not Latino

Mailing Address:
Street or P.O. Box *City* *State* *Zip*

Home Phone	*Work Phone*	*Cell Phone*	*E-MAIL ADDRESS*
( )	( )	( )	

College/School Attending *(if student)*:

School Enrollment Status: [ ] Full Time Student [ ] Part Time Student

PATIENT'S EMPLOYER

Employer Name: **Employer Phone:** ( )

Patient's Occupation:

SPOUSE'S NAME

[ ] NO SPOUSE

Spouse's Name: _____
Last *First* *Middle*

Home Phone	*Work Phone*	*Cell Phone*	*Date of Birth*	*Social Security Number*
( )	( )	( )	/ /	— —

Spouse's Employer:

PERSON RESPONSIBLE FOR BILL NAME

Guarantor's Name: _____
Last *First* *Middle*

Prefix	*Date of Birth*	*Social Security Number*	*Gender*
Miss Mrs. Ms Mr.	/ /	— —	[ ] Female [ ] Male
Home Phone	*Work Phone*	*Cell Phone*	*E-MAIL ADDRESS*
( )	( )	( )	

Relationship to patient (if any): [ ] Self [ ]Spouse [ ] Father [ ] Mother [ ] Other

Mailing Address:
Street or P.O. Box *City* *State* *Zip*

Patient #: _____
(For office use only)

RX: PREFERRED PHARMACY

Pharmacy Name: **Pharmacy Phone: ( )**

Pharmacy Address: **City:** **State:**

EMERGENCY CONTACT NAME:

Emergency Contact Name: _____
Last ***First*** ***Middle***

Mailing Address:
Street or P.O. Box ***City*** ***State*** ***Zip***

Home Phone	*Work Phone*	*Cell Phone*	*E-MAIL ADDRESS*
( )	( )	( )	

Relationship to patient (if any): **[ ] Self [ ]Spouse [ ] Father [ ] Mother [ ] Other**

Please Allow the Receptionist to Copy Your Insurance Card

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

Policy Holder's Name: **Self Spouse Father Mother Other**
Last ***First*** ***Relationship to patient (if any):***
Policy Holder's Employer: ***Date of Birth*** ***Social Security Number***
Policy #: **Group #:** / / — —

SECONDARY INSURANCE COMPANY NAME: _____

Policy Holder's Name: **Self Spouse Father Mother Other**
Last ***First*** ***Relationship to patient (if any):***
Policy Holder's Employer: ***Date of Birth*** ***Social Security Number***
Policy #: **Group #:** / / — —

TERTIARY INSURANCE COMPANY NAME: _____

Policy Holder's Name: **Self Spouse Father Mother Other**
Last ***First*** ***Relationship to patient (if any):***
Policy Holder's Employer: ***Date of Birth*** ***Social Security Number***
Policy #: **Group #:** / / — —

PLEASE COMPLETE THIS SECTION IF PATIENT IS A MINOR OR STUDENT

Mother's Name: _____ ***Date of Birth*** ***Social Security Number***
Last ***First*** / / — —

Father's Name: _____ ***Date of Birth*** ***Social Security Number***
Last ***First*** / / — —

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

PAYMENT POLICY: **Patients are expected to make payment in full for office services at the time of the visit. For your convenience, we accept cash, checks, VISA, and MasterCard. We understand that circumstances sometimes do not make it possible for you to pay in full. When this happens, payment arrangements will be made with our Financial Counselor. Patients who have insurances contracted with us are responsible for any co-payment or deductible at the time of service. Any balance remaining on one of these accounts after insurance payments have been received will become the responsibility of the patient. Accounts with delinquent balances could be reported to the credit bureau or turned over to our collection agency if little or no effort has been made by the patient to settle the amount owed. There will be a $40.00 NSF fee charged to patient's account for any checks returned.**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: **I authorize above office to use my medical information for treatment, payment, and healthcare operations, including submitting information to my insurance company, The Centers for Medicare and Medicaid Services, or the Division of Medicaid or its Fiscal Agent for the purpose of processing claims. I permit the following to be used in place of this document for all federal, state, and private commercial health insurance claims: (1) Photocopy or other facsimile reproduction of this authorization, or (2) Use of computer to indicate my signature is on file at above office, and/or (3) Use of a computer to transmit my insurance claim by phone for processing.**

CERTIFICATION/AUTHORIZATION OF INSURED: **I certify that the insurance information I have provided to above office to be true and correct to the best of my knowledge. I authorize payment for services rendered to the doctors associated with the above office. I understand that the doctor(s) cannot accept responsibility for collecting my insurance claim or for negotiating a settlement on a disputed claim. I am responsible for payment of my account in full within the terms of the above payment policy. If I am under 18, the parent/guardian requesting treatment assumes responsibility. I understand that if my account should ever require action by a collections agency in order to collect the balance owed, fees charged by this agency may be added to the balance due on my account.**

CONSENT FOR TREATMENT: **I authorize the doctors and Woman's Group of Meridian and its designees to provide treatment. I further authorize labs, radiology centers, Pathologist and Radiologists who may interpret and report on diagnostic tests, and Anesthesiologists who will administer anesthesia during a scheduled procedure, to provide such treatment, if such tests/procedures are ordered by my doctor(s). I authorize above office to release all or part of my records to (1) Physicians to whom I am being referred, and/or (2) Any in- or out-patient facility where I am scheduled to receive treatment.**

Please be advised that your medical history is strictly confidential. Absolutely NO information will be released without proper legal consent, unless so deemed by laws of this state.

We may contact you regarding appointment reminders, health care related information, and/or your account information: **I authorize above office to contact me to notify me of a pending appointment or other health care related communication. I also authorize above office to disclose to third parties who answer my phone limited information regarding pending appointments, and to leave a reminder message on my answering machine.**

PAYMENT OF BENEFITS: **All of the information included on this Patient Information form is complete and accurate to the best of my knowledge, and I certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I authorize that payment of medical benefits is made to the physician and/or organization, as directed by the physician and/or organization. I have read and understand the payment policy of Woman's Group of Meridian. I will direct any questions I may have concerning this policy to the Patient Accounting Department before I leave today. I understand that I am responsible for any amount not covered by my insurance company.**

I understand that the clinic's policies about using information might change from time to time and that I can obtain another copy of the notice any time I so desire. I know that I can request restrictions on the way my health care information is used, but I also understand that the clinic is not required to abide by my restrictions.

I have received and had an opportunity to ask question concerning the "Notice of Privacy Practices for Protected Health Information".

By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment and health care operations. You can revoke this consent and the date of revocation.

A "Notice of Privacy Practices" provides a more complete description of the way your medical record might be used and can be obtained, at your request, at the front desk.

SIGNATURE: **DATE:**

and/or Parent, If Patient under 18

WOMAN'S GROUP OF MERIDIAN
FINANCIAL POLICY AND AGREEMENT

Welcome to our practice. We appreciate your selection of this office to provide you with health care. It is our goal to provide you the best possible patient care.

FEES - Our charges are based upon the severity and complexity of your illness. The physician selects the level of service based on these requirements. We regard our fees as reasonable and in keeping with prevailing charges in the area. We are always happy to discuss fees with you, and an estimate of proposed fees would be given for any surgical procedure when requested. Fees/charges are subject to change at any time.

PAYMENT – We request payment for office charges at the time of service. You may use cash, check, MasterCard, or VISA. All co-payments, deductibles, and other amounts not covered by your insurance are your responsibility. Compliance rules set forth by federal and state governments require us to collect copayments. You should be prepared to pay these amounts at the time of your appointment. **There will be a $40.00 NSF fee charged to your account for any checks returned**. You are responsible for payment of services rendered by Woman's Group of Meridian. If you are under 18, parent or guardian requesting treatment assumes responsibility. Full payment is due at the time of service unless you are covered by a contracted insurance or third party coverage plan. ***If your account becomes delinquent and all efforts have been made to collect on your balance, your account may be referred to an outside Collection Agency***. If your account should ever require action by a collection agency or attorney in order to collect the balance owed, fees charged by these agents may be added to the balance due on your account.

I**NSURANCE** - We will file a claim to your insurance as a courtesy to you, but you will be responsible for any co-payment, non covered services, deductible, and/or co-insurance. Please be sure that we have your most current demographic and insurance information at all times. It is your responsibility to provide us with this information. Insurance companies have a time limit in which a claim can be filed. Please notify us immediately if your insurance changes to ensure your claim will be billed to the correct carrier.

Your insurance is a contract between you, the patient, and your insurance company. Your insurance company may notify you of claims denied or applied to your deductible. They do not always notify us. It is your responsibility to follow up on a claim to your insurance carrier if you feel it is not being paid promptly or properly. *In accordance with State of Mississippi regulation, a health insurer is required to pay its claims within 45 days. Should your insurer fail to process a claim within 45 days, they are in violation of the regulations of the State of Mississippi. If you feel your insurer is in violation of the regulations, you may want to contact the MS Department of Insurance.* If your insurance claim has not been processed within 45 days, we will transfer the balance to your responsibility.

Insurance companies have a schedule of fees in which they will pay. Your physician's fee may be more or less than the schedule of your insurance company. We are network providers with many insurance companies. Please check with your insurance company to ensure your doctor is listed as a network provider. **Since every insurance plan is different, be sure to check your coverage and ask questions of your carrier. It is your responsibility to know your coverage and benefits.** Many insurance companies require pre-certification for procedures, some plans may pay 100% for annual wellness exams or do not cover wellness exams at all. A non covered service is any service that is denied by your insurance carrier due to benefit descriptions or limitations, policy exclusions, or pre-existing waiting periods. Non-covered services will be the responsibility of the patient. For your own peace of mind, we advise that you know your insurance benefits. **However, you are ultimately responsible for the FULL payment of your account and for questioning your insurance company about delays in payment and/or the amounts they pay.** Woman's Group of Meridian can only code and file a claim for your visits with a diagnosis that was encountered and documented in your medical records. Thus to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

MEDICAL RECORDS/AND DISABILITY FORMS - All information will be kept in your medical file in our office and will only be passed on to other medical facilities with your written permission. If another physician needs your records, with your permission, copies will be sent at no charge. There is a fee if you request copies sent to someone other than healthcare providers. Disability forms will usually be processed the day we receive them. There is ***a $10.00*** **per form fee** for disability forms. For questions regarding your medical records or disability forms contact the medical secretaries at 482-1002 X 233 or 234.

BILLS FROM HOSPITALS, RADIOLOGY, LABORATORIES, OR OTHER HEALTHCARE PROVIDERS- If your medical services require blood work, a culture or a biopsy; the specimen may be sent to an outside laboratory for analysis. When this occurs you may receive separate bills from that laboratory. If your medical care requires an ultrasound study that is performed in our office, the films may be sent to an outside radiologist for interpretation. You may receive separate bills from the radiologist for the interpretation fee. If you receive medical care for hospital inpatient or outpatient services, your may receive separate bills from the hospital, anesthesia department, or other healthcare providers involved in your care.

I have read this document and I understand my financial responsibilities. I agree to all the terms and conditions and any revisions to those terms and conditions.

_____	_____	_____
Signature of Patient	**and/or Parent, If Patient under 18**	**Date**

If you have any questions about payment options or financial responsibilities, please contact our Financial Services Department at (601) 482-8670. For further information about this policy, contact: Darlene Butler, Practice Manager at (601) 482-1002 Ext 225.

Woman's Group of Meridian PLLC

PLEASE KEEP FOR YOUR RECORDS

Explanation of Medical Billing

For all medical services we provide, we will submit a claim to your Insurance Company. It is extremely important that we have accurate information about your insurance. You will be responsible for any co-payment, deductible, co-insurance, and/or non covered service. A non covered service is any service that is denied by your insurance carrier due to benefit descriptions or limitations, policy exclusions, or pre-existing waiting periods. Non-covered services will be the responsibility of the patient.

After we receive the EOB (explanation of benefits) from your insurance company, we will determine the amount, if any, that you still owe. Your statements will reflect this amount.

You are ultimately responsible for the FULL payment of your account and for questioning your insurance company about delays in payment and/or the amounts they pay.

Introduction
Medical insurance involves 3 common forms of payment to physicians.
These are the **co-pay**, the **deductible**, and the **co-insurance**.

The fee
Medical billing is called fee-for-service. The doctor provides services, and for each service, there is a fee (or a charge). The amount you owe is usually less than the full fee due to fee-reduction contracts between the doctor and your health insurance company. Contrary to what many people believe, insurance does not "cover everything".

The co-pay
The co-pay is the amount of money that you owe up front for every doctor visit. Each insurance plan is different. The co-pay might vary in amount or there might be none. The co-pay needs to be paid in advance at the time of your visit. Some co-pays are as high as $50.00.

The deductible
Many patients have an annual deductible. This is money that the insurance company will determine is owed to the physician, but that the patient has to pay. When a balance due is applied to your deductible, you owe this money to the practice.

The co-insurance
This is the percentage of the fee that is owed to the physician based on your plan. The amount depends on what the insurance has approved for payment. You owe the co-insurance amount to the practice.

If you have any questions about payment options or financial responsibilities, please contact our Financial Services Department at (601) 482-8670.

Woman's Group of Meridian, PLLC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION

PATIENT NAME (Please Print) | PATIENT'S SOCIAL SECURITY # | PATIENT'S DATE OF BIRTH

I hereby authorize to use or disclose of my protected Health information (PHI) as described below. I understand that this information will be given only to those identified on this form and that there is a date after which no further disclosure may be made without further authorization from me.

Doctor/Organization to ***Release Medical Records***

NAME OF DOCTOR YOU ARE REQUESTING RECORDS FROM

ADDRESS OF DOCTOR / ORGANIZATION

CITY | STATE | ZIP

PHONE | FAX

ATTENTION

Doctor/Organization to ***Receive Medical Records***

WOMAN'S GROUP OF MERIDIAN, PLLLC

NAME OF DOCTOR TO RECEIVE YOUR RECORDS

1221 24TH AVENUE

ADDRESS OF DOCTOR / ORGANIZATION

MERIDIAN | **MS** | **39301**

CITY | STATE | ZIP

601-482-6945 | **601-482-1138**

PHONE | FAX

MEDICAL SECRETARY

ATTENTION

Information to be released includes and is limited to any of the information checked below:

_____ **Entire medical record:** includes diagnosis and progress notes, diagnostic test(s) and medications. This information will be used for continuing care.

_____ **Other (specify):** _____

The following information will be released when included in the above information unless you indicate otherwise:

[ ] AIDS or HIV test results
[ ] Alcohol, drug or substance abuse treatment
[ ] Psychiatric or mental care / treatment
[ ] Other (specify):

I UNDERSTAND THAT:

1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY.
2. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.
3. I MAY REVOVE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTION TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AN MAY NOT BE DISCLOSED.
5. THIS AUTHORIZATION EXPIRES 90 DAYS FROM THE DATE OF MY SIGNATURE. AFTER THIS DATE, WOMAN'S GROUP OF MERIDIAN WILL NEED TO OBTAIN A NEW AUTHORIZATION BEFORE RELEASING ANY FURTHER INFORMATION.
6. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

By signing below I understand and accept the terms of this authorization.

SIGNATURE OF PATIENT | DATE

SIGNATURE OF PATIENT'S REPRESENTATIVE (if necessary) | DATE

_____

Authorization Expiration Date (90 days from date of patient's signature)

PLEASE KEEP FOR YOUR RECORDS

WOMAN'S GROUP OF MERIDIAN
NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION

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

Woman's Group of Meridian is dedicated to protecting your Medical Information (MI) or Protected Health Information (PHI). We are required by law to maintain the privacy of PHI and to provide you with this notice of our legal duties and privacy practices with respect to PHI. We are required by law to abide by the terms of this Notice, making any revision applicable to all of the PHI we maintain. If we revise the terms of this Notice, we will post a revised notice at the Office and will make paper copies of this Notice of Privacy Practices. Your PHI is available for review upon request.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

We will use your protected health information (PHI) as part of rendering patient care. For example, your PHI may be used by the health care professional treating you, by the business office to process your payment for the services rendered and by our staff reviewing the quality and appropriateness of the care received.

We may also use and/or disclose your information in accordance with federal/state laws for the following:

- Unless you object, we may disclose to family members other relatives or close personal friends, the medical information directly relevant to such person's involvement with your care. List Exclusions (if any):

- Unless you object, we may use or disclose your MI to notify a family member, or other person responsible for your care of our location and your general condition, or death. List Exclusions (if any):

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you.
- We may disclose medical information (MI) when required by the U.S. Department of Health and Human Services as part of an investigation or determination of the Practice's compliance with relevant laws.
- We may use or disclose your MI for public health activities, including the reporting of disease, injury, and the conduct of public health surveillance. We may disclose your MI concerning abuse, neglect, or violence in accordance with federal and state law.
- We may disclose your MI in the course of certain judicial or administrative proceedings.
- We may disclose your medical information for law enforcement purposes/other specialized governmental functions.
- We may disclose your medical information to a coroner, medical examiner, or funeral director.
- If you are an organ donator, we may disclose your MI to an organ donation and procurement organization.
- We may use or disclose your medical information for certain research purposes.
- We may use or disclose your MI to prevent or lessen a serous threat to health & safety of another or the public.
- We may disclose your MI as authorized by laws relating to Workers Comp or other programs.

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you can revoke your authorization at any time.

If you need an explanation of any of these uses, please ask the receptionist.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights with respect to your medical information:

- The right to request restrictions on certain uses and disclosures of your Protected Health Information (PHI). We are not required to agree to your requested restriction, but if we do, we will honor it.
- The right to receive communications from us in a confidential manner.
- The right to inspect and copy your medical information. This right is subject to certain specific exceptions and you may be charged a reasonable fee for any copies of your records.
- The right to request an amendment of your medical information. We may deny your request for certain specific reasons, and, if denied, we will provide you with written explanation for the denial and information regarding further rights you would have at that point.
- The right to receive an accounting of the disclosures of your medical information in the six years prior to your request (following April 14, 2003), except for disclosures for treatment, payment, or practice operational purposes, disclosures pursuant to an authorization and certain other specific disclosure types.
- The right to request a paper copy of this Notice of Privacy Practices for Protected Health Information.
- The right to complain to the Practice and/;or to the U.S. Department of Health and Human Services, if you believe that the Practice has violated your privacy rights. To complain to the Practice, please call:

Darlene Butler, Compliance Officer at (601) 482-1002 Extension 225.

If you choose to file a complaint, you will not be retaliated against in any way.

THIS NOTICE IS EFFECTIVE AS OF April 15, 2003.

OFFICE HOURS:

This office is open from 8 a.m. till 5 p.m. Monday through Thursday. After 4:30 p.m. calls are answered by our answering service. In an emergency, they will locate the physician on call.

This office is open from 8 a.m. till 12 p.m. on Friday. After 11:30 a.m. calls are answered by our answering service. In an emergency, they will locate the physician on call.

This office is closed on weekends and most holidays. On weekends and holidays calls are answered by our answering service. In an emergency, they will locate the physician on call.

HOSPITALS:

Our physicians are on staff at Rush Hospital and Anderson Hospital.

TELEPHONE CALLS:

Our telephone number is 601-482-1002.

During regular office hours, you can reach voice mail for your Physicans Nurse directly by dialing:

Dr. Harris (Nurse)	601-484-7572
Dr. Hamilton (Nurse)	601-484-7571
Paulette Hopkins (Nurse)	601-484-7570
Heather Patchin, WHNP (Nurse)	601-484-7568
Nicole Powe, CNM-WHNP (Nurse)	601-484-7570

Thank you for choosing Woman's Group of Meridian for your healthcare needs. For your convenience, we are enclosing the paperwork you will need to complete before your first visit with us. Please bring this packet with you to your appointment with Dr._____ on _____ at _____ .

In addition to completing these forms we need you to bring your current insurance card and your driver's license (or other picture ID card). If you are not the policy holder named on your insurance card, you will need to provide the policy holder's social security number and date of birth.

We request that you arrive 15 – 20 minutes early to help ensure that you are able to see the doctor on time. If you need to discuss your financial responsibilities before your appointment, please call our billing department at 601-482-8670.

Thank you again for choosing Woman's Group of Meridian. We look forward to seeing you.