INNOVATIONS
IN WOMEN'S HEALTH

Please make sure to bring your photo id, current insurance card, medication list, and list of all surgeries.

Patient Information - (PLEASE PRINT)

Full Name: _____

Complete Address: _____

P.O Box: _____ City: _____ Zip Code: _____

Cell: (____) _____ - _____ Work: (____) _____ - _____ Home: (____) _____ - _____

Date of Birth: ____ / ____/____ Social Security: _____-____-_____ Marital Status: _____

Name of Employer: _____

Occupation: _____

Email Address: _____

Patient Spouse Information – (PLEASE PRINT)

Spouse Name: _____

Spouse Address: _____

Spouse Cell: (____) _____ - _____ Spouse Work: (____) _____ - _____

Spouse Date of Birth: ____ / ____/____ Spouse Social Security: _____-____-_____

Spouse Employer: _____

Spouse Occupation: _____

Primary Care Physician Information

Primary Care Physician Name: _____

Primary Care Physician Number: _____

Dependent or Minor: Please fill out below information for the parent/guardian who is the primary insurance card holder

Card Holder Full Name: _____

Card Holder Address: _____

Card Holder Date of Birth: ____ / ____/____ Card Holder Social Security: _____-____-_____

Cell Number: (____) _____ - _____ Work Number: (____) _____ - _____

Card Holder Employer: _____

Card Holder Occupation: _____

INNOVATIONS
IN WOMEN'S HEALTH

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Innovations in Women's Health originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for the future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means for communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Innovations in Women's Health is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization my refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Innovations in Women's Health reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Innovations in Women's Health change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **ACCEPT** / **DECLINE** the terms of this consent.

_____ _____

Patient's Signature Date

OFFICE USE ONLY

____ Consent received by: _____ on _____.

____ Consent refused by patient, and treatment refused as permitted.

____ Consent added to the patient's medical record on _____.

INNOVATIONS
IN WOMEN'S HEALTH

Assignment of Insurance Benefits Form

I, _____, do hereby assign payment benefits from my insurance carrier directly to Innovations in Women's Health for medical services render to me or my dependents. I understand the insurance company may not completely cover the fee(s) for professional services rendered to me. I understand that I am responsible for charges that are deemed the patient's responsibility by my insurance carrier and Innovations in Women's Health.

_____ _____

Patient Signature Date

INNOVATIONS
IN WOMEN'S HEALTH

HIPPA Notice and Acknowledgement of Privacy Notice

Acknowledgement:

I acknowledge that I have received the attached Notice of Privacy Practices:

_____	_____
Signature of Patient/Personal Representative	Print Name
_____	_____
Account Number	Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient:

_____