Women's Healthcare Associates

We have added a text messaging system. This may be used to:

- Notify you to call our office to discuss labs.
- Notify you of necessary changes to your appointment.
- Remind you of specific recommendations prior to procedure.
- Notify you of changes in our clinic hours due to severe weather.
- Notify you of referrals to another office with instructions and directions.
- Notify you of medications being sent to your pharmacy.

Please note the following:

- Your phone number will not be shared with any other individuals or groups.
- We will never use this system to text you with any sensitive medical information.
- STANDARD DATA AND MESSAGE RATES MAY APPLY BASED ON YOUR MOBILE PLAN.

If you consent to receiving these text messages, please print your name and list your mobile number below, so that we may opt you in:

_______________________ ____/____/____
Print Name Date of Birth

_______________________ ____/____/____
Signature Date

____
Mobile Number

2. **If you DO NOT consent to receiving text messages from our office, please sign below so that we may opt you out:**

_______________________ ____/____/____
Print Name Date of Birth

_______________________ ____/____/____
Signature Date

Please complete forms and bring to your appointment, Thank you

PATIENT INFORMATION

NAME: ______________________

ADDRESS: ______________________

____

SSN: ______________________

DATE OF BIRTH: ______________________

MARTIAL STATUS: [ ] MARRIED [ ] SINGLE

[ ] DIVORCED [ ] WIDOWED

CELL: ______________________

HOME: ______________________

EMAIL: ______________________

EMERGENCY CONTACT: ______________________

____

PHONE: ______________________

RELATIONSHIP: ______________________

PATIENT EMPLOYMENT

[ ] EMPLOYED [ ] RETIRED [ ] OTHER

EMPLOYER: ______________________

PHONE: ______________________

GUARANTOR FOR INSURANCE

NAME: ______________________

DATE OF BIRTH: ______________________

RELATIONSHIP: ______________________

Would you like to be notified regarding future appointments or reminders via text message? [ ] YES [ ] NO

Authorization & Consent; I authorize the release of Medical information necessary to process my insurance claim. I authorize payment to Atlanta Women's Health Group, P.C. for any surgical and or medical benefits. I understand that payment in full is expected at the time of service. I authorize the physicians of Atlanta Women's Health Group to treat me. I consent to medical evaluation and treatment for office based procedures, necessary for my healthcare and understands that this consent shall not expire. IT IS MY RESPONSIBILITY TO INFORM Atlanta Women's Health Group IF I AM ON MEDICARE.

PATIENT SIGNATURE: ______________________ DATE: ______________________

Women's Healthcare Associates
355 Hawthorne Lane
Athens, GA 30606

Telephone: (706)369-0019 Facsimile: (706)369-1983

Website: womenshealthcareassociates.com

Stephanie Allen, M.D.
Leah Lowman, M.D.
Sandi Hayes, NP
Alexa Clay, CNM
Meredith Turner, CNM, PhD
Andrew H. Leach, M.D.
Lina Maria Millan, M.D.
Sarah M. Carey, PA-C
Amy Gutermuth, CNM

REQUEST FOR RECORDS FROM ANOTHER DOCTOR OR FACILITY

I, THE UNDERSIGNED PATIENT (OR PERSON AUTHORIZED TO CONSENT FOR THE PATIENT) HERBY AUTHORIZE THE RELEASE OF INFORMATION LISTED BELOW FROM THE RECORDS OF:

PATIENT NAME: ______________________ D.O.B. ______________________

ADDRESS: ____

FROM:

DOCTOR OR FACILITY: ____

ADDRESS: ____

TELEPHONE/FAX NO: ____

RECORDS REQUESTED: ____

TO:

Women's Healthcare Associates
355 Hawthorne Lane
Athens, GA 30606
TELEPHONE: 706-369-0019
FAX: 706-369-1983

I UNDERSTAND THE AUTHORIZATION INCLUDES RELEASE FROM ALL MEDICAL RECORDS INCLUDING HUMAN IMMUNODEFIENCY VIRUS RECORDS, PSYCHIATRIC, DRUG/ALCOHOL ABUSE RECORDS, VENERAL DISEASE, AND ANY OTHER STATUTURY PROTECTED DISEASE. THIS AUTHORIZATION AND CONSENT WILL EXPIRE (90) DAYS FOLLOWING THE DATE SIGNED. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AND CONSENT AT ANY TIME EXCEPT THAT ACTION THAT HAS BEEN PREVIOUSLY TAKEN IN RELIANCE HEREOF.

______________________ PATIENT SIGNATURE

______________________ DATE OF SIGNATURE

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I acknowledge that I have had the opportunity to review a copy of Women's Healthcare Associates, LLC ("WHA") Notice of Privacy Practice ("Notice"). I understand that I am responsible to read this Notice and notify WHA, in writing, of any request for the restrictions in the use or disclosure of my protected health information ("PHI"). I understand WHA has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.womenshealthcareassociates.com. WHA will provide me with a copy of its most recent Notice upon my request.

If Women's Healthcare Associates, P.C. has signed contract with my insurance company, provisions of the contract will be followed. Otherwise charges for the office visits are due at the time of service. Other procedures covered by insurance will be filed as a courtesy.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize Women's Healthcare Associates, P.C. to disclose portions of my records or other privileged information (to include alcohol, drug dependence, or AIDS status) necessary to process insurance on my behalf or to assist in my care. This includes the release of information to the referring physician, primary care physician, or facility involved in my medical care. I also hereby assign all medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and other health plans, to Women's Healthcare Associates, P.C. for unpaid charges.

I understand I am responsible for seeing that all my charges are paid in a timely manner. Deductibles, co-insurances, co-pays, non-covered services, and all other balances not covered by insurance are my responsibility.

I hereby acknowledge that I have been provided with a copy of Women's Healthcare Associates Notice of Privacy Practices. The notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPPA") that may be made by the practice's legal duties with respect to my protected health information. I have had the opportunity to review the notice and take a copy with me if I choose.

____ I DO NOT authorize the release of my medical information to anyone.

____ I authorize the release of my medical information to the individual(s) listed below:

______________________________ (Individual) ______________________________ (Individual)

______________________________ (Individual) ______________________________ (Individual)

______________________________ (Individual) ______________________________ (Individual)

______________________________ ______________________________ ______________________________

Patient Printed Name Patient/Guardian Signature Date