WOMEN'S SURGERY & Aesthetics Center

1726 Gunbarrel Road Chattanooga, TN 37423 (423) 899.6511

Patient Information: *(please print clearly)* **Date:**_____ **Arrival Time:** _____ **Account #** _____

Last Name: _____ New Patient ❑ Yes ❑ No

First Name: _____ MI: _____ Phone Number: *(check preferred contact number)*

DOB: _____ SSN: _____ ❑ Home: _____

Address: _____ ❑ Mobile: _____

City: _____ State: _____ ❑ Work: _____

Zip: _____ Email Address: _____

Can we call to remind you of your appointments? ❑ Yes ❑ No

Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Preferred Language: ❑ English ❑ Spanish ❑ French ❑ German ❑ Vietnamese ❑ Japanese ❑ Portuguese ❑ Chinese (Mandarin) ❑ Other: _____

Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander ❑ White ❑ Other: _____

(check all that apply)

Are you: ❑ Hispanic or Latino ❑ Non-Hispanic or Latino

Emergency Contact:

Name: _____ Telephone # _____

Relationship to Patient: _____

Insurance Information:

Name of Primary Insurance: _____

Member ID: _____ Group # _____

Name of Subscriber: _____ DOB: _____

Relation to Patient: ❑ Parent ❑ Spouse ❑ Partner ❑ Other: _____

Name of Secondary Insurance: _____

Member ID: _____ Group # _____

Name of Subscriber: _____ DOB: _____

Relation to Patient: ❑ Parent ❑ Spouse ❑ Partner ❑ Other: _____

Employment:

Employer: _____ Employer Phone: _____

Employer Address: _____

How did you hear about our office? _____

Patient Signature_____

REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION

I agree to allow my medical information to be released without restriction to the following individuals:

I request the following restrictions or limitations on the health information you have about me regarding treatment, payment, or healthcare operations or surgeries:

I am aware that I have the right to revoke or change my above listed restrictions, limitations, and contacts at any time in writing.

Patient Signature_____Date:_____

PERMISSION TO PHOTOGRAPH

I agree that Women's Surgery & Aesthetics Center may take a digital photo of me.

I understand that:

- The photo will be stored permanently in my medical record.
- The photo will be used to identify me when I come here for care
- The photo will be stored securely to protect my privacy
- The photo will NOT be used outside of the clinic unless I (or my legal representative) give permission in writing
- Women's Surgery & Aesthetics Center will own the photo. I can look at the photo and I can get copies of the photo if I (or my legal representative) sign a release form.

Patient Signature_____Date:_____

Or

❑ I decline

Sign here if you wish to decline **Date**

AUTHORIZATION AND CONSENT FOR TREATMENT

I request care from Women's Surgery & Aesthetics Center for treatment of my medical health condition. This care may include tests, exams, or other treatments that are needed for my condition. I agree to this care.

Insurance and Payment Information:

Women's Surgery & Aesthetics Center will receive payment for patient care from insurance companies, Medicare, and/or other third party programs.

1. I agree to have my insurance company, Medicare, or other third party program make payments directly to Women's Surgery & Aesthetics Center.
2. I agree to let my doctor(s) and/or Women's Surgery & Aesthetics Center submit claims and required treatment information to my insurance company, Medicare, or other third party program for my care, and receive payments directly.
3. I understand that I must pay all charges, co-payments, and deductibles that are not covered by my insurance company, Medicare, or other third party program.

Missed Appointment Policy:

I hereby acknowledge that if I or the patient for whom I am responsible for, fail to arrive for a scheduled appointment without canceling a minimum of 24 hours prior to the scheduled time, will be considered a "no show" and agree to pay a $50.00 fee for missing a scheduled appointment.

Permission to Communicate with Your Primary Care Physician and/or Other Community Care Providers:

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician, other community care providers, and your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care. Many insurance companies will require us to document whether or not you will allow your clinician to communicate with your primary care physician and/or your Health Insurance Company.

Patient Signature_____Date:_____

Authorized Staff Signature_____Date:_____

PATIENT HIPAA CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" also known as "HIPAA" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records.
We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient Signature_____Date:_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

I have received a copy of Women's Surgery & Aesthetics Center Notice of Privacy Practices

Patient Signature_____Date:_____

Authorized Staff Signature_____Date:_____

CONTROLLED SUBSTANCE CONTRACT

U.S. Government statistics indicate that Tennessee shows 23% of population abuse rate of narcotics, 5% being prescription medications illegally used or redistributed. This makes Tennessee one of the top eight abusers of the country. Due to this, the government has instituted a narcotics monitoring website. Reflecting state goals, we now require a contract for compliance with narcotic prescriptions, as follows.

By signing below, I agree to the terms set forth by the physicians of this practice. I understand that the doctor may prescribe controlled substances for me based on the history that has been given by me, and that these have a high potential for addiction. Also, I have been completely honest in my presentation of my symptoms. I understand the physician has the right to refuse prescribing all controlled substances for me and discharge me from the practice if I do not abide by the rules of this contract.

I contract to do the following:

1. I will take controlled medication as prescribed. I will not use more or less of the medication without my doctor's approval of change.
2. I will not obtain controlled substances from any other source (ER, other physician, dentist, etc.) without notifying my doctor at the Women's Surgery & Aesthetics Center.
3. I will not give, sell, or abuse this medication. If I am suspected of doing such, the doctor has the right to report me to the appropriate authorities.
4. I will not alter my prescription in any way or attempt to forge prescriptions.
5. I will not request early refills for lost or stolen prescriptions.
6. I will not call the office's answering service after hours to request a refill.
7. I will not use more than one pharmacy for filling a controlled substance prescription.
   Pharmacy: _____ Phone: _____
8. I will not request that a refill for this prescription be called into a pharmacy. I understand that I must take the prescription to the pharmacy myself.
9. I will make monthly appointments to monitor symptoms and follow all treatment plans prescribed by my physician and any other providers to whom I may be referred, including, but not limited to, physical therapy, occupational therapy, mental health professionals, or other providers as deemed necessary by my doctor.

Patient Signature_____Date:_____

Authorized Staff Signature_____Date:_____

CONSENT TO OBTAIN MEDICATION HISTORY

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form, you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

This medication history is a helpful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements, or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for Women's Surgery & Aesthetics Center to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Patient Signature_____Date:_____

Authorized Staff Signature_____Date:_____

Women's Surgery & Aesthetics Center

Notice of Privacy Practices

To Our Valued Patients:

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Thank you for being one of our highly valued patients.

Our office is fully committed to compliance with HIPAA guidelines by:

1. Providing appropriate ***security*** for our patient records.

2. Protecting the ***privacy*** of our patient's medical information.

3. Providing our patients with proper ***access*** to their medical records

4. Appropriately maintaining our patient information and billing processes in compliance with national ***standards***.

If you ever have any questions or concerns about your services or charges, we encourage you to call and ask for our Practice Manager.

(Patient Copy)