Professional Women's Healthcare, P.A.
805-B Tilghman Drive
Dunn, NC 28334
www.PWHealthcare.com
Phone: 910-897-7711

PATIENT INFORMATION

Last Name:_____ **First Name**:_____ **MI**:___

Date of Birth:_____ **SSN**:_____ **Marital Status**: S___M___D___Sep___W__

Mailing Address:_____ City_____ State_____ Zip_____

Phone:_____ H/C/W **Second Phone**:_____ H/C/W

Email:_____ **Preferred Pharmacy**_____

Language:_____ **Ethnicity**: Hispanic or Latino_____ Non-Hispanic or Latino_____

Race (may pick 2): Asian____Caucasian____Black/Afr.Amer.____Amer.Indian____Hawaiian____Pac.Isl.____

If patient is a minor, **Guarantor's Name**:_____ DOB:_____

Guarantor's Address:_____

Phone:_____ SSN:_____ Relationship to Patient:_____

Primary Insurance: Insurance Company_____

Policy #_____ Group #_____

Policy Holder_____ Policy Holder's DOB_____ Relationship_____

Secondary Insurance: Insurance Company_____

Policy #_____ Group #_____

Policy Holder_____ Policy Holder's DOB_____ Relationship_____

Contact Persons In Case of Emergency:

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

ALL CHARGES ARE DUE AT THE TIME OF SERVICE. ALL PROFESSIONAL CHARGES RENDERED ARE CHARGED TO THE PATIENT. DIAGNOSTIC RECEIPTS WILL BE FURNISHED UPON REQUEST.

I AUTHORIZE THOMAS GIEBMANNS, MD AND PROFESSIONAL WOMEN'S HEALTHCARE TO RELEASE MEDICAL INFORMATION TO SUBMIT INSURANCE CLAIMS AND FOR OTHER PHYSICIAN'S REQUESTS RELATING TO MY MEDICAL CARE. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS FOR ANY PROFESSIONAL CHARGES DIRECTLY TO THOMAS GIEBMANNS, MD AND PROFESSIONAL WOMEN'S HEALTHCARE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

Signature_____ Date_____

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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

The Patient hereby consents to the use or disclosure of her individually identifiable heath information ("protected health information or PHI") by Professional Women's Healthcare, P.A. ("PWH") in order to carry out treatment, payment, or healthcare operations. The Patient should review PWH's Notice of Privacy Policies for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

PWH reserves the right to change the terms of its Notice of Privacy Policies at any time. If PWH does change the terms of its Notice of Privacy Policies, Patient may obtain a copy of the revised Notice upon request.

Patient retains the right to request that PWH further restrict how her PHI is used or disclosed to carry out treatment, payment or healthcare operations. PWH is not required to agree to such restrictions (unless required by law); however, if PWH does agree to Patient's required restrictions, such restrictions are then binding on PWH.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to PWH in writing. The revocation shall be effective except to the extent that PWH has already taken action in reliance on the Consent.

PWH may refuse to treat Patient if she (or an authorized representative) does not sign this Consent (except to the extent required by law). If Patient (or an authorized representative) signs this Consent and then revokes it, PWH has the right to refuse to provide further treatment to Patient as of the time of the revocation (except to the extent required by law).

If you consent to the following**, please initial below**:

_____ **I understand and acknowledge receipt of Professional Women's Healthcare, P.A.'s Notice of Privacy Practices**. If I wish to receive a hard copy, one will be provided to me upon my request.

_____ **I agree that Professional Women's Healthcare, P.A. may electronically obtain my prescription history from a third-party pharmacy database, in order to update my health records**.

_____ **I agree that Professional Women's Healthcare, P.A. may electronically send me information related to my health records via its Patient Portal** *(please make sure we have your current email on file)***.**

Patient's Signature	Printed Name	DOB	Date
Authorized Representative's Signature*	Printed Name	Date	
Witness's Signature	Printed Name	Date	

*Please state Authorized Representative's relationship to Patient and provide us with any documents pertaining to your authority to act on behalf of the Patient:_____

MEDICAL RECORDS REQUEST

Patient's Full Name_____
Any Other Names Patient May Be Listed As_____
Address_____
City, State, Zip_____
Date of Birth_____

I hereby request the following medical records in the possession of the provider, including, but not limited to, records, reports, tests or information concerning mental illness or developmental disabilities, psychotherapy notes, HIV/AIDS testing or treatment, communicable diseases, venereal diseases, substance abuse, abuse of an adult with a disability, sexual assault, child abuse and neglect, genetic testing and abortions (***if you wish to limit the material disclosed above in any way, please indicate exactly what you do not want released***):

Please initial:

___	Complete Medical Record	___	Emergency Reports
___	Clinic Notes	___	Lab Results
___	Operative Reports	___	Pap Smear Results
___	Pathology Reports	___	Mammogram Reports
___	Ultrasound/X-Ray Reports	___	Discharge Summaries
___	Other: _____		

For the following dates of treatment: (for example: specific date, range of dates, all dates of service)
_____

be released by Fax ____ or Mail ____

FROM:(name)	**TO**: Professional Women's Healthcare, P.A.
(address)	805-B Tilghman Drive
(address)	Dunn, NC 28334
(tel. #)	Tel.: (910) 897-7711
(fax #)	Fax: (910) 897-2654

The purpose of the disclosure is: ___ continued patient care ___ other:_____

***This request is valid for 6 months from date of the above signature. I understand that I may change my mind and revoke this Medical Records Request in writing at any time by notifying the Privacy Officer. I understand that changing my mind will not affect my treatment. The revocation will not apply to the extent that Professional Women's Healthcare has already taken action where it relied on my permission. I understand that I have the right to inspect or copy any information used/disclosed under this authorization. I understand that I may refuse to sign this Medical Records Request, and if I do refuse, my ability to obtain treatment will not be affected unless the only purpose of treatment is to create health information for the disclosure listed above. I have read and understand this Medical Records Request and had a chance to ask questions about the disclosure of health information. I authorize Professional Women's Healthcare, P.A. to use my health information in the manner described above.

X_____
Signature of Patient Date

OFFICE POLICIES

Thomas Giebmanns, M.D., FACOG

Welcome to *Professional Women's Healthcare, P.A.* We are honored that you have chosen us as one of your healthcare providers. Our mission is to provide you with top quality care. We look forward to treating you.

Office Hours: For our Dunn location, our office hours are Monday through Friday from 8:15 am to 5:15 pm. We are closed for lunch from 12:30 to 1:30. Surgeries are provided Friday mornings. After hours you may call our office, and our answering machine will either let you leave a message or direct you to call Dr. Giebmanns's pager in the case of an emergency. We will now be seeing patients at our Lillington location on Wednesday afternoons. Please use our main phone number at 910-897-7711 to contact either location.

Patient Information: It is your responsibility to notify us immediately of any change in your name, address, telephone number(s), or health insurance plan(s). It is crucial that we have a way to contact you to confirm appointments and to notify you of any health problems that we may diagnose.

Cancellation and No Show Policy: In respect for our staff and for other patients, we ask that you contact us as soon as possible and at least 24 hours in advance if you must cancel a scheduled office visit. If you fail to call in advance and do not show for your appointment, it will be counted as a "no show." *1st No Show*: The patient will receive a phone call informing her that she has missed her appointment without notifying our office. *2nd No Show*: The patient will receive a letter informing her that she has missed two appointments without notifying our office. *3rd No Show*: The patient will be charged a $25.00 fee and will receive a letter informing her that her account has been flagged as recurrent no shows and that another missed appointment will result in dismissal from the practice. *4th No Show*: We will no longer be able to serve you.

Health Insurance:

Authorization, Co-Payment and Deductible Payments: If you are a member of a managed care organization, it is your responsibility to obtain an authorization from your primary care physician *prior to your visit*. Failure to do so will significantly delay your visit or may necessitate rescheduling your appointment. Since insurance companies usually refuse to issue a retroactive authorization for office visits, Dr. Giebmanns will be unable to see you unless we have an authorization or you are willing to accept full responsibility for the entire cost of the services rendered. Payment of all co-pays and deductible amounts (when applicable) are required at the time of your visit. For surgeries, we require that you pay these funds by the time of your pre-op visit.

Insurance companies with whom we have a contract: We will file your insurance for you. In return, you or your guardian agrees to assign any insurance benefits payable to Professional Women's Healthcare, P.A. *Delay in insurance payment*: If your insurance company does not pay your claim within 45 days of submission, we may forward the bill to you and ask for your assistance in getting the claim paid. If your insurance company does not pay for a legitimate claim within 60 days after submission, we may enlist your help to register a complaint with the insurance commissioner. *Insurance company denials*: You (or your guardian) are responsible for being familiar with your health insurance policy benefits and exclusions. Certain benefits may not be covered. For instance, many policies deny coverage for problems relating to infertility and/or preexisting conditions. If your policy excludes benefits for a particular condition and you elect to see Dr. Giebmanns for this condition, you or your guardian are responsible for payment in full for services rendered. Insurance payments may also be denied for other reasons. Our policy is to appeal denied claims. We may ask for your help in disputing a denied claim with your insurance company. However, if a denial is final, you or your guardian agrees to pay the amount due unless the reason for the denial is our fault.

Insurance companies with whom we do not have a contract: As a courtesy, we will file your insurance claim for you. In return, we expect payment in full at the time of your visit for services rendered. If your insurance policy does not offer out-of-network benefits, we offer a discount off our regular fee schedule.

Financial Policy: Payment is required upon check-in. If there is a balance on your account, payment is required prior to being seen again. It is your or your guardian's responsibility to notify our office of any referral authorizations, pre-admission certification and/or second opinion requirements of your insurance company at the time of scheduling office appointments, hospital admissions or surgery. If our office is not notified *in advance* of these requirements, this document acts as a waiver, and you or your guardian agrees to be responsible for payment of services rendered.

Charge for Copying Medical Records: There will be a charge for copying records that exceed 20 pages in length to cover our expenses for processing and postage. Also, a signed HIPAA release of medical records form will be required before records will be released.

Payment: We gladly accept cash, checks, debit cards and credit cards (Visa and Mastercard only). Please note that we must verify funds in your account for all checks of a substantial amount.

Returned checks: If your check is returned for any reason, a $25 returned check fee will be assessed, and we will no longer be able to accept checks from you. You will be required to rectify any payments due before your next appointment.

Self pay: As a courtesy to our self pay patients, we offer a discount off our regular fee schedule, which is comparable to the reimbursement we receive from insurance companies. In return, we expect payment in full at the time of your office visit. Surgeries require payment at the time of your pre-op visit.

Surgeries: If you require surgery, we will verify insurance benefits and provide you or your guardian with an estimate of the amount you will be responsible for. This will consist of any deductible you have not met for the plan year in addition to your co-insurance. The estimated amount is due in full **prior** to your surgery at your pre-op visit.

Collection policy: Unless payment arrangements have been made, all "patient due" accounts (once your insurance company has paid its portion of the claim, or from the time of service for self pay patients and patients with insurance companies that we do not participate with) over ninety (90) days old will be turned over to a licensed debt collection agency. In addition to being liable for your outstanding balance, any additional court costs and attorney fees that are required to collect your outstanding balance will be charged to you.

Drug Screening: ***In order to protect the health of you and your infant, we may randomly screen any patient for drug use. By signing this form, you consent to being tested.***

Attestation: Your signature or the signature of your guardian acknowledges that you understand and accept the above information.

Patient's Signature	Patient's Printed Name	Date
Guardian's Signature	Guardian's Printed Name	Date
Witness's Signature	Witness's Printed Name	Date

Professional Women's Healthcare, P.A.
805-B Tilghman Drive, Dunn, NC 28334, 910-897-7711

NOTICE OF PRIVACY POLICIES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Introduction: At Professional Women's Healthcare, P.A. (PWH) we are committed to treating and using your protected health information responsibly. This Notice of Privacy Policies describes the protected health information we collect, and how and when we use and disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective January 1, 2015, and applies to all protected health information that we create or obtain in providing services to you. We protect the privacy of that information in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and applicable privacy laws.

Understanding Your Protected Health Information: Each time you visit PWH, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This record also contains charges and billing documents for the services you receive. This record serves as a basis for planning your care and treatment, means of communication among the many health professionals who contribute to your care, legal document describing the care you received, means by which you or a third-party payer can verify that services billed were actually provided, tool in educating health professionals, source of data for medical research, source of information for public health officials charged with improving the health of this state and the nation, source of data for our planning and marketing, and tool with which we can assess and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your record and how your protected health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your protected health information, and make more informed decisions when authorizing disclosure to others.

Your Rights with Respect to Your Protected Health Information: Although your health record is the physical property of PWH, the protected health information in your record belongs to you. You have the right to:

- obtain a paper copy of this Notice upon request
- inspect and copy your protected health information as provided by 45 CFR 164.524
- amend your protected health information as provided by 45 CFR 164.526
- obtain an accounting of disclosures of your protected health information as provided by 45 CFR 164.528, request that communications of your protected health information be made by alternative means or at an alternative location as provided by 45 CFR 164.522 - we will accommodate all reasonable requests and will notify you if we deny your request
- request restrictions on certain uses and disclosures of your protected health information as provided by 45 CFR 164.522. If you ask us not to disclose health information to your health plan for items or services for which you paid in full and out of pocket, **we are required to honor this request** and we will not disclose the information to the plan. In all other cases, we are not required to agree to a requested restriction
- revoke your authorization to use or disclose protected health information at any time as described below except to the extent that action has already been taken pursuant to your authorization
- receive notification of any breach of your unsecured PHI caused by us

To exercise any of these rights, submit your request in writing with the required information to the following person: Privacy Officer, 805-B Tilghman Drive; Dunn, NC 28334, (910) 897-7711. The Privacy Officer will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities: PWH is required to: maintain the privacy of your protected health information as required by law, provide you with this Notice about our legal duties and privacy practices with respect to protected health information we collect and maintain about you, and abide by the terms of this Notice. We will post this Notice in our office and, to the extent that we maintain a comprehensive website, on such website. We reserve the right to change or eliminate provisions in our Notice of Privacy Policies and to make the new provisions effective for all protected health information that we maintain and any protected health information that we receive in the future. Should our privacy policies change, we will revise this Notice and post the updated Notice in our office and, as applicable, on our website. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of the Notice or by visiting our office and requesting a copy. We will not use or disclose your protected health information without your authorization, except as described in this Notice. We will also discontinue use or disclosure of your protected health information after we receive a written revocation of the authorization according to the procedures included in the autorization.

For More Information or to Report a Problem: If you have questions or would like additional information about our privacy policies, you may contact the Privacy Officer at (910) 897-7711 or in writing at 805-B Tilghman Drive, Dunn, NC 28334. If you believe that your privacy rights have been violated, you can file a complaint with the Privacy Officer in writing at 805-B Tilghman Drive; Dunn, NC 28334. You may also file a complaint by mailing it or emailing it to the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing within 180 days of the time when you became aware or should have become aware of the issue giving rise to your complaint. We will not require you to waive the right to file a complaint with the Privacy Officer or the Secretary of the Department of Health and Human Services as a condition of receiving treatment from our office. We will not retaliate against you for filing a complaint with either the Privacy Officer or the Secretary of the Department of Health and Human Services. The address for the Secretary of the Department of Health and Human Services is: Region IV, Office for Civil Rights U.S. Department of Health and Human Services 61 Forsyth Street, S.W., Suite 3B70 Atlanta, GA 30323-8909 Telephone: (404) 562-7886 Fax: (404) 562-7881 TDD: (404) 331-2867 Email: OCRComplaint@hhs.gov

How We May Use and Disclose Your Protected Health Information: The rest of this Notice describes the ways we may use and disclose your protected health information. Generally, we will only use and disclose your protected health information as authorized by you or as required or permitted by law. Although not every specific use or disclosure is listed, the reasons for which we are permitted or required by law to use or disclose your protected health information generally will fall under one of the categories described below. HIPAA generally does not take precedence over State or other applicable privacy laws that provide individuals with greater privacy protections. As a result, when a State law requires us to impose stricter standards to protect your protected health information, we will follow State law instead of HIPAA.

Treatment: We may use and disclose your protected health information to provide health care treatment to you. For example, information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

Payment: We may use and disclose your protected health information to obtain payment for services. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Health Care Operations: We may use and disclose your protected health information in performing business activities, or "health care operations." For example, members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use your protected health information to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: We may arrange for other individuals and entities, referred to as "Business Associates", to perform various functions and activities on our behalf and to provide certain services. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your protected health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your protected health information, however, we require our business associates to appropriately safeguard your information.

Notification: We may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or another person responsible for your care, of your location, your general condition as long as you have either agreed to the use or disclosure or have not objected after being given the opportunity. If you are not present or are unable to agree (for example, due to your incapacity or an emergency), then we may use our professional judgment to determine whether the use or disclosure is in your best interest.

Communication with family: We may disclose to a family member, other relative, close personal friend or any other person you identify, protected health information relevant to that person's involvement in your care or payment related to your care if you have either agreed to the disclosure or have not objected after being given the opportunity. If you are not present or are unable to agree (for example, due to your incapacity or an emergency), then we may use our professional judgment to determine whether the use or disclosure is in your best interest.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board (or other appropriate privacy board) that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Appointment Reminders and Treatment Alternatives: We may contact you to provide you with appointment reminders, information about treatment alternatives, or information about other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose your protected health information to a representative of the FDA to report adverse events (with respect to food or dietary supplements) or product defects or problems (including problems with the use or labeling of a product), to conduct post marketing surveillance and to enable product recalls, repairs, or replacement.

Workers' compensation: We may disclose your protected health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Public health: We may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose your protected health information for law enforcement purposes in certain circumstances, for example, in response to a valid subpoena or other legal process or to help a law enforcement official identify or locate certain individuals.

Abuse, Neglect or Domestic Violence: We may disclose your protected health information to appropriate governmental authorities as allowed by law if we believe that you may be a victim of abuse, neglect or domestic violence.

Health Oversight Activities: We may disclose your protected health information so that government agencies can monitor and oversee the healthcare system and government benefit programs and be sure that certain healthcare entities are following regulatory programs or civil rights laws they should.

Judicial or Administrative Proceedings: We may disclose your protected health information as required for judicial and administrative proceedings. For example, if you are involved in a lawsuit or dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request or other lawful process from someone else involved in the dispute, but only if efforts are made to tell you about the request or to obtain an order protecting the information requested.

Coroners and Medical Examiners: We may disclose your protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or for performing other duties as authorized by law.

To Avert a Serious Threat to Health or Safety: We may use or disclose your protected health information in accordance with applicable law, if we believe the use or disclosure is necessary to prevent or lessen a serious and immediate threat to the health or safety of a person or the public.

Specialized Government Functions: If you are or were a member of the armed forces, we may disclose your protected health information as required by military command authorities. We may also disclose protected health information about foreign military personnel to the appropriate foreign military authority. In addition, we may disclose your protected health information to authorized federal officials for national security and intelligence activities.

Correctional Institutions: If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may release your protected health information to the correctional institution or law enforcement official if the disclosure is necessary to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Disaster Relief: We may use or disclose your protected health information in order to assist in disaster relief efforts if you have either agreed to the disclosure or have not objected after being given the opportunity. If you are not present or are unable to agree (for example, due to your incapacity or an emergency) then we may use our professional judgment to determine whether the disclosures are in your best interest.

U.S. Department of Health and Human Services: We are required to disclose your protected health information to the Department of Health and Human Services when it is investigating or determining our compliance with HIPAA.

Required by Law: We may use or disclose your protected health information to the extent that such use or disclosure is required by law and the use or disclosure is limited to the relevant requirements of such law.

Disclosures pursuant to your authorization: Most uses or disclosures of your PHI for marketing purposes, the disclosure of any psychotherapy notes, and the disclosure of PHI by sale, require your prior written authorization. Further, the use or disclosure of your PHI not described in this Notice will require your written authorization.

Exception to these Permitted Uses and Disclosures – Communicable Diseases: If you have one of several specific communicable diseases (for example, tuberculosis, syphilis, or HIV/AIDS), North Carolina law requires that information about your disease be treated as confidential, and such information will be disclosed without your written permission only in limited circumstances. We may not need to obtain your permission to report information about your communicable disease to State and local officials, or to otherwise use or disclose information in order to protect against the spread of the disease. Also, we may disclose such information without your consent to health care personnel who provide medical care to you.

Special Provisions for Minors under North Carolina Law: Under North Carolina law, minors, with or without the consent of a parent or guardian, have the right to consent to services for the prevention, diagnosis and treatment of certain illnesses, including venereal disease and other diseases that must be reported to the State, pregnancy, abuse of controlled substances or alcohol, and emotional disturbance. If you are a minor and you consent to one of these services, you have all the authority and rights included in this Notice relating to that service. In addition, the law permits certain minors to be treated as adults for all purposes. These minors have all rights and authority