Professional Women's Healthcare, P.A.
103 Hunt Drive Dunn, NC 28334
www.pwhealthcare.com
Ph. 910-897-7711 Fax 910-897-2654

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI:** ____

Date of Birth: _____ **SSN:** _____ **Marital Status: S__ M __ D __ Sep __ W __**

Mailing Address: _____ **City** _____ **State** _____ **Zip** _____

County: _____ **Phone:** _____ **H/C/W** **2nd Phone:** _____ **H/C/W**

Email: _____ **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 pt:** _____

YOU MUST INFORM THIS OFFICE OF ALL INSURANCE POLICIES YOU HAVE. IF YOUR CLAIMS ARE NOT FILED CORRECTLY, YOU WILL BE RESPONSIBLE FOR PAYMENT

Primary Insurance Company: _____

Policy # _____ **Group #** _____

Policy Holder _____ **Policy Holder's DOB** _____ **Relationship** _____

Secondary 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 GIEBNANNS, 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** _____

Professional Women's Healthcare, P.A.
103 Hunt Drive Dunn, NC 28334 Ph. 910-897-7711 Fax 910-897-2654
www.pwhealthcare.com

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

The Patient hereby consents to the use or disclosure of her individually identifiable health information ("protected health information or PHI") by Professional Women's Healthcare, P.A. ("PWHC") in order to carry out treatment, payment, or healthcare operations. The Patient should review PWHC'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.

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

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

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

PWHC may refuse to treat Patient if she (of 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, PWHC 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 record 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: _____**

Professional Women's
HEALTHCARE P.A.

OFFICE POLICIES

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.

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. Any ultrasound appointment that is either missed or canceled without a 24 hour notice will be assessed a fee. Any scheduled surgery that is either missed or canceled without a 48 hour notice will be assessed a fee.

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, debit cards and credit cards.

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.
103 Hunt Drive
Dunn, NC 28334
(910) 897-7711

PROFESSIONAL FEES FOR SURGERY
Rescheduling and Cancellation Policy

Upon scheduling a surgery to be performed by Dr. Thomas Giebmanns at Harnett Health/Betsy Johnson Hospital, our office will contact your insurance company to confirm your surgical benefits for our services. After benefit verification, we will contact you with a surgical estimate that will be due on the date of your pre-operative appointment. This is only an estimate for Dr. Giebmanns' professional fees alone and will be billed through Professional Women's Healthcare, P.A.

CFV Betsy Johnson Hospital is a separate entity and it is your responsibility to contact them prior to surgery for an estimate of payment due for the procedure performed. Please call 910-904-8311 if you have not received a phone call to pre-register or have not been made aware of your estimated payment for hospital fees prior to your pre-operative visit.

Please note that there may also be anesthesiology, pathology, labs or other fees that are billed separately, as these providers are contracted through the hospital to provide services for its patients.

- **If you need to reschedule or cancel your surgery, you must give 48 hour notice prior to your pre-op appt time in order to avoid a $50 cancellation fee.**

By signing below, I acknowledge that I have read the above policy, and understand and accept the terms there of.

Patient Printed Name:_____ **DOB:**_____

Patient Signature: _____ **Date:**_____

Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Professional Women's Healthcare, P.A.
103 Hunt Drive Dunn, NC 28334
(910)897-7711

ASSIGNMENT OF BENEFITS TO CLINTON X-RAY ASSOCIATES, P.A.

I authorize direct payment of benefits to Clinton X-Ray Associates, P.A. for services rendered. I authorize same to file my insurance. I am responsible for any balance not paid by my insurance company. I am also responsible for charges from Clinton X-Ray Associates, P.A. that is not a covered service by my insurance company.

I hereby authorize Clinton X-Ray Associates, P.A. to release any medical information that may be necessary for medical care or the continuity of medical care by Professional Women's Healthcare, P.A. for the processing of insurance benefits by Clinton X-Ray Associates, P.A.

OB ULTRASOUND CONSENT

An ultrasound exam is a painless diagnostic procedure done to assess your pregnancy. It involves the use of sound waves to make a picture of the uterus and its contents (baby, placenta, fluid, etc.). Ultrasounds have been in use for over 20 years and have been extensively studied. To date, there has been no evidence of harmful effects on either the mother or the baby.

Your office ultrasound is **NOT** done to diagnose birth defects. Sophisticated ultrasound technology and training is needed to determine if fetal abnormalities are present. This is beyond the capabilities of our office (some birth defects are not visible with even the most advanced techniques).

While the sex of the child may be seen, this is not a 100% guarantee that this is accurate.

Please sign below indicating that you are electing to have an ultrasound performed by us, GYN or OB, have read this consent form and understand the above information. I must give a 24 hour notice to cancel or reschedule my ultrasound appt or I will be charged a $25 fee. This fee must be paid before rescheduling.

Patient's Name (Printed) : _____

Patient's Signature: _____

Birthdate: _____

Valid from date: _____ **Until revoked by the patient in writing.**