ADVANCED WOMEN'S HEALTH OF NASHVILLE
OBSTETRICS • GYNECOLOGY • INFERTILITY

AdvancedHEALTH

PATIENT INFORMATION

Patient Name: First_____MI_____ Last_____

Preferred Name_____**DOB**_____**SS#** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner

Race: _____**Ethnicity**: ☐ Not Hispanic ☐ Hispanic ☐ Latin ☐ Declined

Address: _____

City_____**State**_____**Zip**_____

Phone: Home_____Cell_____ Work_____

E-Mail_____

Best Contact Method: ☐ Home ☐ Cell ☐ Work ☐ E-Mail ☐ Mail By checking one of the boxes for Best Contact Method, I agree to receiving correspondence from AWH

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Student ☐ Disabled ☐ Retired

Employer/School:_____**Occupation**_____

Primary Care Physician_____**Referral Source**_____

Messages: We may leave the following on your voice message? ☐ Appointments ☐ Account information ☐ Lab and pathology results
May we send your lab and pathology results by email via the secure portal? ☐ Yes ☐ No

FINANCIALLY RESPONSIBLE PARTY

☐ **Same as Patient Information** *(If different, please complete section below)*

Name: First_____MI_____ Last_____

Relationship: Spouse Parent Guardian Other (Please Specify): _____

Address: _____Apt #_____ City_____St_____Zip _____

Phone: Home_____ Cell_____ Work_____

Email Address _____Employer:_____

EMERGENCY NOTIFICATION AND SPOUSE/PARTNER INFORMATION

Emergency contact Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

Spouse/Partner Name: _____

Phone: Home_____ Cell_____ Work_____

PHARMACY INFO AND MEDICATION REFILL

Please contact your pharmacy for medication refills. Your Pharmacy will fax us a medication refill request which the physician will review. Refill authorizations may require 48-72 hours. Please allow enough time for us to process your refill request. **Initials** _____

To enhance your care, we access your prescription history and pharmacy benefit files that are available electronically based on pharmacy, state, and insurance data. Please indicate here if you wish to deny this access. ○ **I elect to OPT-OUT**

Pharmacy Name_____ Phone_____

Address _____

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

I authorize Advanced Women's Health and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters checked below. This authorization will remain in effect until I provide written notification to Advanced Women's Health of changes or update.

Name _____ Relationship_____ Phone_____

You may release the following information to the person named above: □ Appointments □ Billing Information □ Medical Care □ Leave Message

Name _____ Relationship_____ Phone _____

You may release the following information to the person named above: □ Appointments □ Billing Information □ Medical Care □ Leave Message

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC.

Spouse □ YES □ NO

Relative □ YES □ NO Specify:_____

Other □ YES □ NO Specify_____

I understand that Advanced Women's Health reserves the right to ask the person picking up the above for identification before releasing.

I authorize AdvancedHealth/Advanced Women's Health of Nashville (AWH) to provide medical treatment. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to AWH for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. I understand that payment for today's visit and future visits are due at the time of treatment. I understand that AWH is part of a single multi-specialty physician group Advanced Health and that any physicians I see in this network may have access to some of my medical history. We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing. If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we must refer your account to a collection agency, you agree to pay all the collection costs which are incurred. If we must refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances. A photocopy of this authorization shall be considered as effective and valid as the original.

_____

Patient/Guardian signature **Date**

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GENERAL CONSENT FOR TREATMENT

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care.

I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ **(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient: _____ Date: _____

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**
☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone:_____

Address: _____

Signature of the above: _____ Date: _____ Time: _____
Signature of Witness: _____Date: _____ Time:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date:_____ _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials:_____Employee Name_____

Reason: _____

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

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

• **Treatment:** We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary, to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.

• **Payment:** We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.

• **Health operations:** We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.

• We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain lawsuits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

• You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.

• You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

• We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.

• You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.

• Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.

• You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.

• You have the right to receive a copy of this notice, either electronic or paper or both.

• You have the right to opt out of fund-raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer: Ryan D. Brown
Mailing Address: 28 White Bridge Pike, Suite 111, Nashville, Tennessee 37205
Telephone: 615.986.6153
Fax: 615.234.1515
Email Ryan.Brown@OurAdvancedHEALTH.com

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on 10/01/09