

## The Woman's Group

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1615 Hospital Parkway, Ste 204, Bedford, TX 76022 ■ Phone: 817-684-5002 ■ Fax: 817-684-5150

Please Note: So that we may maintain the most up to date and accurate information on our patients, in addition to the face sheet presented to you at every visit, we will request that you review and update this form at least once a year.

### Patient Information

Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Best Contact Number \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_

Marital Status Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Employer: \_\_\_\_\_

Email Address \_\_\_\_\_ *(Confidential Medical Information Will **NOT** Be E-Mailed)*

Ethnic Group: Caucasian \_\_\_\_\_ African/American \_\_\_\_\_ Hispanic \_\_\_\_\_ Other \_\_\_\_\_ Are you employed? yes/no FT \_\_\_\_\_ PT \_\_\_\_\_ Self \_\_\_\_\_ Retired \_\_\_\_\_

Preferred Language: English \_\_\_\_\_ Spanish \_\_\_\_\_ Other \_\_\_\_\_ Are you a student? yes/no FT \_\_\_\_\_ PT \_\_\_\_\_

### Spouse/Parent/Legal Guardian Information

Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Relationship: Spouse Parent Guardian Other (Please Specify): \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_ *(Confidential Medical Information Will **NOT** Be E-Mailed)*

Preferred Language: English \_\_\_\_\_ Spanish \_\_\_\_\_ Other \_\_\_\_\_

### Emergency Notification

Check box if same as spouse/legal guardian. If different, please complete information below.

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

## Please provide a copy of all Insurance Cards and a Driver's License / Photo ID

You will be asked to present your insurance card(s) at each visit so that we can confirm that all information in our files remains current.

### Primary Insurance Information

Please present your card at each visit

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|                        |                       |      |       |     |
|------------------------|-----------------------|------|-------|-----|
| Insurance Company Name | Claim Mailing Address | City | State | Zip |
|------------------------|-----------------------|------|-------|-----|

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|           |        |         |
|-----------|--------|---------|
| Telephone | Group# | Policy# |
|-----------|--------|---------|

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|                 |               |               |                         |
|-----------------|---------------|---------------|-------------------------|
| Primary Insured | Insured's DOB | Insured's SS# | Relationship to Patient |
|-----------------|---------------|---------------|-------------------------|

Employer: \_\_\_\_\_

### Secondary Insurance Information

Please present your card at each visit

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|                        |                       |      |       |     |
|------------------------|-----------------------|------|-------|-----|
| Insurance Company Name | Claim Mailing Address | City | State | Zip |
|------------------------|-----------------------|------|-------|-----|

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|-----------|--------|---------|
| Telephone | Group# | Policy# |
|-----------|--------|---------|

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|                 |               |               |                         |
|-----------------|---------------|---------------|-------------------------|
| Primary Insured | Insured's DOB | Insured's SS# | Relationship to Patient |
|-----------------|---------------|---------------|-------------------------|

Employer: \_\_\_\_\_

### Cancellation Policy

Any appointment you are unable to keep must be cancelled at least 24 hours in advance of the appointment time. **You may be charged \$25 for appointments not cancelled at least 24 hours in advance.** Insurance companies do not cover this expense. This charge will be the sole responsibility of the patient. You may be dismissed from the practice if you repeatedly NO SHOW for scheduled appointments without providing sufficient notice.

\_\_\_\_\_ Initial

### Medication Refill Policy

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. The physician on call does not refill medication after hours or on the weekend. Please allow sufficient time for us to process your refill request.

\_\_\_\_\_ Initial

### Privacy Practices

Our office, physicians and staff, are committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Practices.

A copy of the Notice of Privacy Policies for The Woman's Group has been made available to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## The Woman's Group

1615 Hospital Parkway, Ste 204, Bedford, TX 76022 Phone: 817-684-5002 Fax: 817-684-5150

### Patient Authorizations

Our primary mission is to provide you with quality, cost effective medical care. It is important that we have a good understanding with our patients, regarding financial responsibility. We hope this summary will be helpful in explaining your responsibility and the expectations in maintaining a positive relationship.

Please understand that financial responsibility for medical services rest between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. We encourage you to ask questions if you do not understand any area.

- Co-payments and applicable deductibles are due at the time of service unless other arrangements have been made with our office
- If you are uninsured or if the services being provided are not covered by your insurance, you will be expected to provide payment in full at the time services are rendered
- If you receive a payment from your insurance in error, please bring it along with any paperwork to our office

#### 1. Consent to Treatment

I hereby consent to evaluation, testing and treatment as directed by my physician or his/her designee.

\_\_\_\_\_Initial

#### 2. Assignment of Insurance Benefits/Patient Financial Responsibility

I hereby authorize direct payment of my insurance benefits to the Texas Health MedSynergies for services rendered to my dependents or me by Texas Health MedSynergies providers or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered by my benefits. I understand and agree that I will be responsible for any co-pay or balance due that Texas Health MedSynergies is unable to collect from my insurance carrier for whatever reason.

\_\_\_\_\_Initial

#### 3. Medicare/Medicaid/Insurance Benefits

I request that payment from Medicare/Medicaid or any other insurance carrier be made on my behalf to Texas Health MedSynergies. I authorize the release of any of my or my dependent's records that these programs may request. I authorize any holder of medical information about me to be released to the Center for Medicare and Medicaid and its agents or insurance company and any information needed to determine these benefits payable for related services.

\_\_\_\_\_Initial

#### 4. Lab/X-Ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray or diagnostic services. I also understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for any reason.

\_\_\_\_\_Initial

#### 5. Authorization to release Non-Public Personal Information and receipt of Privacy (HIPAA) Policy

I certify that I have received and read a copy of the Patient Information Privacy Policy. I hereby authorize Texas Health MedSynergies to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for evaluation, treatment, consultation or the processing of insurance benefits.

\_\_\_\_\_Initial

I do not wish my information to be disclosed to any person

\_\_\_\_\_Initial

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

\_\_\_\_\_Initial

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

#### 6. Authorization to Mail, Call or E-mail

I certify that I understand the privacy risks of the mail, phone calls and e-mail. I hereby authorize a representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying the Texas Health MedSynergies in writing.

\_\_\_\_\_Initial

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information and payment of any services not covered or approved by my insurance carrier.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date