REGISTRATION

PLEASE PRINT -- **BLACK** INK ONLY

Northeast Texas Women's Health, P.A.

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PATIENT INFORMATION

NAME ______ LAST NAME ______ FIRST NAME ______ INITIAL ______ SOCIAL SECURITY ______

BIRTHDATE ______ MARITAL STATUS S / M / D / W RACE: ______

MAILING ADDRESS ______

CITY ______ STATE ______ ZIP ______

HOME ADDRESS (IF DIFFERENT) ______ STREET NUMBER ______ CITY ______ STATE ______ ZIP ______

HOME PHONE ( ) ______ ALTERNATE PHONE ( ) ______

FAX ( ) ______ EMAIL ______

PATIENT EMPLOYED BY ______ OCCUPATION ______

BUSINESS ADDRESS ______ BUSINESS PHONE ______

EMERGENCY CONTACT ______ RELATIONSHIP ______

HOME PHONE ( ) ______ ALTERNATE PHONE ( ) ______

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT ______ LAST NAME ______ FIRST NAME ______ INITIAL ______

RELATIONSHIP TO PATIENT ______ BIRTHDATE ______

SOCIAL SECURITY ______ PHONE ( ) ______

ADDRESS (if different from patient's) ______

CITY ______ STATE ______ ZIP ______

PERSON RESPONSIBLE EMPLOYED BY ______ OCCUPATION ______

INSURANCE COMPANY ______

GROUP # ______ POLICY # ______ CO-PAY $ ______

ADDITIONAL INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT ______ LAST NAME ______ FIRST NAME ______ INITIAL ______

RELATIONSHIP TO PATIENT ______ BIRTHDATE ______

SOCIAL SECURITY ______ PHONE ( ) ______

ADDRESS (if different from patient's) ______

CITY ______ STATE ______ ZIP ______

PERSON RESPONSIBLE EMPLOYED BY ______ OCCUPATION ______

INSURANCE COMPANY ______

GROUP # ______ POLICY # ______ CO-PAY $ ______

We check insurance eligibility and medication history electronically, as needed, on our patients. Please notify us in writing if you do not wish for this to be done.

______
Patient Signature

______
DATE

Informed Consent for Collaborative Care
at
Northeast Texas Women's Health, P.A.

This practice provides care for women for obstetrical and gynecological services. We currently have two board-certified OB/GYN physicians and a certified nurse midwife. To provide improved access and quality of care, you, as the patient, have the right to choose to establish care with either a physician or midwife.

A certified nurse midwife is a registered nurse that has received a master's degree and furthered their education in the fields of obstetrics and gynecology. They have been certified as an advanced practice nurse by the Texas Board of Nurse Examiners. They meet the requirements and are recognized by the American College of Nurse-Midwives. They are required to maintain a current license and to engage in required continuing medical education. They practice independently with the supervision of a qualified physician. They practice within certain guidelines based on experience and scope of practice.

If you choose a midwife for your care, you will receive the same level of care within the scope of midwifery practice as you would a physician in our clinic. This office has developed practice guidelines for the care of our patients. Both physicians and midwives practice by these guidelines. If you develop a problem outside the scope of the midwife's practice, you will be referred for consultation to one of the OB/GYN physicians in this office. In the event that your situation remains beyond the scope of the midwife's practice, your complete care will be transferred to a physician.

If you choose to establish care with a physician, your healthcare will be provided by that physician. However, there may be times that you will see another physician from this practice or the midwife. This may occur secondary to emergencies or scheduling problems. If your care is provided by this midwife, you are assured that the midwife is acting under guidelines approved by this clinic and accepted standards of care. However, it is your right to request to see a physician. This request may involve being rescheduled to a different time or day.

The availability of both physician and midwife providers in this clinic is intended to enhance the level of care for our patients. We look forward to serving your healthcare needs. Please sign below indicating that you understand your choices as explained above.

______________________________ ______________

Signature of Patient Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____

Signature of Patient or Personal Representative

____

Date

____

Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

Patient Name ______________________________ **Date of Birth** _________

NORTHEAST TEXAS WOMEN'S HEALTH, PA FINANCIAL POLICY

Thank you for choosing us as your women's health care provider. We are committed to providing you with the best possible medical care. Please understand payment of your bill is considered a part of your treatment. The following information is provided to avoid any misunderstanding or disagreement concerning payment for services provided by our office.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
   - Bring your current insurance card to every visit and notify us of changes in coverage.
   - We will submit a claim to your insurance company for you. Balances not paid, per our contract by your primary insurance company may be billed to your secondary payer. A monthly statement will be sent to you. ***Ultimately*** you are responsible for payment of charges.
   - Be prepared to pay your co-pay at each visit. Payment can be made by cash, check, Mastercard, Visa, American Express, or Discover.
2. If you do not have insurance coverage or if you are insured by a company with which we are not contracted, payment in full is expected at time of service unless payment arrangements are made and kept.
3. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however should be directed to your insurance company member services department (number should be on your insurance card)
4. This office charges for all services that are significant and separately identifiable. Patients that are seen for physical exams and require other treatments for illnesses or problems may be charged separately for each service even when both services are provided on the same day.
5. This office can only code and file a claim for a patient's visit with a diagnosis that was encountered and documented in the medical record. To request a diagnosis change solely for the purpose of securing reimbursement from the insurance carrier is inappropriate and could be considered a fraudulent act.
6. All balances billed are due within 30 days of the statement date. Unpaid balances greater than 30 days are subject to our collection process. Accounts sent to our collection agency are subject to a collection charge of $50.00 for balances up to $150.00 and for balances of $150.01 and higher the fee is 35% of the outstanding balance.
7. Co-pays not paid at time of service may result in a processing fee.
8. There is a $25.00 fee on all returned checks.

Patient/Guardian's Initials ________

9. Yearly well woman exams may or may not be covered under your health insurance policy, however, they may be required by your physician. Some forms will not be filled out and/or signed if physicals are not up to date.
10. If you miss or no show for three (3) appointments you may be dismissed from the practice.
11. **MINORS** – For all services rendered to patients under 18 years old, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

By signing below, I certify that I will pay Northeast Texas Women's Health, PA, any co-payments, co-insurance, deductibles or non-covered services. I will immediately pay to Northeast Texas Women's Health, PA, any payments that I receive from my insurance company for services provided to me or my dependents. I will also be responsible for any amounts not paid by insurance because I have not provided the appropriate insurance information for billing.

I understand and agree that if my account is delinquent, Northeast Texas Women's Health, PA may deny me or my dependent, as named below, further supplies and services or may require that I pay for supplies and services at the time of the visit.

I certify that the information I have provided is a true and complete statement according to my best knowledge and belief, and that a full explanation of services and charges has been given to me. I understand that if given false information, withhold information or fail to report changes promptly, I will be breaking the law and can be prosecuted and/or have services discontinued.

_______________________________________ ____________________

PRINT PATIENT'S NAME DATE

____

SIGNATURE OF PATIENT OR GUARDIAN

____

WITNESS

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Northeast Texas Women's Health, PA for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Northeast Texas Women's Health to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Northeast Texas Women's Health on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

______________________________ __________________

Patient/Responsible Party Signature Date

______________________________ __________________

Witness Date

Rev 10/27/11

Northeast Texas
Women's Health, P.A.

2001 N Jefferson, Suite 220
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HIPAA ACCESS FORM FOR PROTECTED HEALTH INFORMATION

I understand that it is the policy of Northeast Texas Women's Health, PA to restrict access to my Protected Health Information. In addition to the caregiver(s) providing health services, and my insurance company(ies) for payment claim, I would like for the following person/people to have my Private Health Information:

NAMES (Please Print)	DOB	All or Restricted*
1. **Myself (Patient or Legal Guardian)**		
2.		
3.		
4.		
5.		

*Clinical Information Restricted – Please specify any clinical information you **DO NOT** wish to share with the person(s) listed above:

____

____

____

____

Patient/Guardian Signature   Date   Witness Signature

NOTE: State law permits both parents to have access to PHI unless we are provided a court order restricting the right.

Northeast Texas Women's Health, P.A.
2001 N. Jefferson Suite 220
Mount Pleasant, Texas 75455
Phone (903) 572-4664 Fax (903) 572-4647

Patient Informed Consent for Use of Patient Portal

Northeast Texas Women's Health is now offering a patient portal as a secure, HIPPA compliant tool as a courtesy to our patients. It is an optional service and we reserve the right to suspend or terminate it at any time. We will you to any changes as promptly as possible. This form is intended to inform you of the facts and risks surrounding the use of the use of the web portal. By signing below, you confirm that you have read, understand, and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold the clinic or any of its staff liable for network infractions beyond their control.

Privacy and Security

The web portal has a secure connection with our clinic that uses encryption to keep unauthorized persons from being able to access and read your health information or your communications with us. To help us insure the tunnel remains secure, we need to have your current email address and be informed if it changes. Keep your portal user ID and password secure so that only you, or someone authorized by you, can gain access to patient information. If you think someone has learned your password, immediately go to the portal and change it.

Your email address is confidential and protected information. We will never share this information with any third party.

All access to our internal network and electronic medical record (EMR) is password protected. Our staff is instructed to logoff their workstations when not present. In addition, in compliance with HIPAA guidelines, our EMR automatically logs the user out after a period of inactivity.

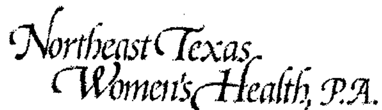
The portal may be used for patient forms, medication management, appointment reminders and requests, communications with staff, and other features as needed. Similar to phone communications, messages may be read and addressed by different staff at different times throughout the day. These messages will be answered as quickly as possible. In an urgent or emergent situation, direct contact to the clinic is still the preferred option.

Confidential email, please print clearly:____

Patient Name:________________________________ Date of Birth:____________________

Responsible party if different than patient:____

Signature:________________________________ Date:______________________



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How to Use Our Patient Portal

Initial Set Up:

1. Request access from our office.
2. Review and sign the Portal Activation Consent Form
3. You will then receive a welcome email, from which you can log into the portal.
4. Once logged into the portal, click the "My Account" button on the top right. Here you can change your username and password to something only you will know. This is essential to ensure security and privacy!
5. You are now set up to use the portal!

Available Components:

1. *Messages:* This component allows you to send and receive secure email to/from our staff. When you receive a message from our office, you will receive an email asking you to log into the portal and retrieve it. You may also send messages to our staff:
   a. Melissa Mason - Billing/Surgery Scheduling/Financial Issues
   b. Teresa White, RN – Patient care issues/results for Dr. Mason and Martha's patients
   c. Margaret Taylor, RN – Patient care issues/results for Dr. Slovak
   d. Alyssa, Azeneth, or Azucena(Suzy) – Scheduling or Demographic questions
   e. Christopher Mason, MD, FACOG – Specific medical questions or surgery
   f. Melissa Slovak-Tucker, MD, FACOG – Specific medical questions or surgery
   g. Martha Deming, RN, MSN, CNM – Specific medical questions

2. *Lab/test Results*: Here you can receive copies of labs/test ordered by our office.

3. *Health Summary*: This section allows you to view parts of your electronic medical record we have on file. The information in this section is information which has been provided by you, mostly based upon forms you filled out on your first visit. You can comment or request changes to the information, once approved by a staff member those changes will be reflected online.

4. *Medications*: Here you can see your current and past medications written by our office or entered by our staff. Medications which do not list a physician are ones not prescribed by our office, but are ones you told us you are taking. You can request refills of medications we prescribed by clicking on the medications and then clicking Request Refill on the left. Be sure to include your pharmacy information. We will review your request and notify you when approved.

5. *Appointments*: In this section, you can view upcoming appointments. You will receive a reminder message when an appointment is close. You may request a wait list appointment to try and get in sooner if desired.
   Our Patient Portal site is: **www.gotomyclinic.com/netwh**

NORTHEAST TEXAS WOMEN'S HEALTH, PA
2001 N. Jefferson, Suite 220
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903-572-4664

NAME: ______________________ DATE OF BIRTH: ____________

FAMILY MEDICAL HISTORY

CONDITION	RELATION
Diabetes	____________
Heart problems	____________
High blood pressure	____________
Clotting disorders	____________
Birth Defects	____________
Cancer	____________
Other	____________

SOCIAL HISTORY

Marital status S / M / D / W / Other ____________

Hobbies: ______________________

Do you exercise? Y / N

Type: ____________

Frequency: ____________

Are you currently dieting? Y / N

Have you ever used tobacco products? Y / N

Do you still use tobacco products? Y / N

Type: Cigarettes Cigars Smokeless

Frequency: ____________

Do you drink alcohol? Y / N

Frequency: ____________

Do you, or have you, ever used illicit drugs? Y / N

Frequency: ____________

Are you taking any herbal supplements? Y / N

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NAME: ______________________________ DATE OF BIRTH: ____________

MEDICATIONS

Please list any of the medications that you are currently taking:

____

____

Are you allergic to any medications? YES NO

If YES, please list medication(s) and reaction(s):

____

____

____

PAST MEDICAL HISTORY

Please list any conditions or illnesses you have had in the past:

____

____

____

Please list any procedures or surgeries you have had in the past:

____

____

____

OB/GYN HISTORY

Date of last pap smear: ______________

Age period started: ______

Date of last menstrual period: ____________

Number of Pregnancies: ____________

Number of children: ________

Number of miscarriages: ________

Number of Abortions: _______

Date of last mammogram: ______________

Age at menopause: ______

Any menstrual problems? Y / N

Any pregnancy problems? Y / N