Yakima Women's Health, PLLC. Patient Demographics

Patient Information				☐ Minor ☐ Married ☐ Single
Last Name: **Apellido:**	**If Minor- Responsible Party Name & Phone#:**			
First Name: **Nombre:**	**MI:**	**SSN#:**		**Race/Ethnicity:**
Date of Birth: **Fecha de Nacimiento:**	**AGE:** **Edad:**	**Language:**		**Home Phone:** **Telefono Casa**
Address: **Domicillo**				**Wk Phone:** **Trabajo**
City: **Ciudad:**	**State:** **Estado:**	**Zip:**		**Cell Phone:** **Celular**
Employer:		**Occupation:**		
Email Address:		**Referring or Primary Care Physician:**		
Restrictions: ☐ **YES** ☐ **NO** **May we leave a message with anyone who answers your phone?** **Authorized Account Access Name and DOB:**				
Emergency Contact Person				
Last Name:	**First Name:**		**Phone:**	
Spouse Information				
Name:		**DOB:**	**SSN#:**	
Place of Employment:			**Contact Phone:**	

Patient No-Show / Late Cancellation Policy

This notice is to inform you that if you fail to give us a 24-hour notice of cancellation for future appointments, there will be a $40.00 fee billed to your account. This fee is **NOT** covered by your insurance and you will be responsible for this fee. Several no-shows, late cancellations and multiple reschedules can result in being discharged from the office.

Signature: ______________________________ Date: ________________________

Assignment and Release:

I hereby authorize payment directly to my provider for all insurance benefits otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges, whether the service is allowed and paid by my insurance. This includes any and all services rendered on behalf of my dependents. I also understand that it is my responsibility to know when my maximum benefits have been reached and I agree to pay for services at the full fee thereafter. I authorize my provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have read, understand, and agree to the above.

Signature: ______________________________ Date: ________________________

OFFICE PAYMENT POLICY

As part of our commitment to offer excellent medical and professional care to you, we would like to present our office payment policy in order to minimize misunderstandings about fees. Our fees and methods of payments are comparable with other Gynecologists and Obstetricians in the Yakima area. We ask for payment at the time of service. This includes payment for the office visit, procedures, and any tests that are performed. We commonly require payment at the time of check-in.

Any laboratory tests which require an outside lab company to perform will be billed separately by that company.

As a courtesy, we will file all applicable office and hospital charges with your insurance carrier(s). By your signature below, you authorize and request that insurance payments be made directly to Yakima Womens Health, PLLC. **However, you are ultimately responsible for all charges.** We advise that you familiarize yourself with the benefits of your insurance plan. Prior to any procedure, we may assist you in determining your portion of the bill. This usually includes any un-met deductible, co-payment and co-insurance which are to be paid prior to the procedure. We accept Cash, Checks, Visa, MasterCard or CareCredit.

You are responsible for your co-payment, deductible, coinsurance, and/or any non-covered services as set by your insurance carrier. Known Patient Responsibility is collected at the time of service. **If your insurance carrier requires a referral number to receive services from our office, it is your responsibility to contact your Primary Care Physician to obtain the number prior to your office visit.**

This policy is offered in an attempt to develop and sustain a continued professional and pleasant relationship. Your cooperation is greatly appreciated.

***Monthly statement rebilling fee of $4.00 on any unpaid balances over 60 days past due:**
_______ (Patient Initials)

***NO SHOW FEE: New or Established patients WILL be charged a $40 No Show Fee if 24 hour notice of cancellation or rescheduling of your appointment has not been made.**
(Your insurance will not be billed or pay for this fee) ________ (Patient Initials)

***Require $150.00 down payment for all office procedures and surgeries** _______ (Patient Initials)

***Require a minimum payment of $30.00 on unpaid balances** _________ (Patient Initials)

***All balances are to be paid in FULL within 6 months from the Date of Service to prevent collection actions**
________ (Patient Initials)

CONSENT TO TREATMENT AND PRIVACY

I authorize and consent to all examination and treatment necessary for the care of the patient named below and consent to any and all procedures incident to such treatment which are deemed necessary by the physician at Yakima Womens Health, PLLC including but not limited to blood and urine tests, drug tests, and any other diagnostic procedures or treatment. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

I have read and understand the above policies and consent to treatment.

______________________________________ Date: ________________________

Patient Signature

Print Name: __________________________ Relationship to Patient: __________________

Yakima Women's Health, PLLC
1020 S. 40th Ave Ste, C
Yakima, WA 98908
509-966-3969

ACKNOWLEDGEMENT OF:
NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. 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 that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

______________________________	______________________	__________
Patient/Guarantor Signature	***Print Name***	***Date***