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Member of American College of
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Dear Patient,

Greensboro Women's Health Care provides reproductive health care, counseling, and education for women in all phases of their unique health needs. Our services include annual examinations, contraceptive counseling, treatment of abnormal pap smears, infertility evaluation, menopausal care, and gynecologic surgery. Our physicians and our nurse practitioners are all board certified.

Allow approximately two hours for your first visit to our office. We spend this time with you reviewing your health history, addressing your medical needs, and answering your questions.

Enclosed are a registration form and a copy of our Financial Policy. Please complete these forms and **bring them with you at the time of your appointment.** Be sure to bring your current insurance card(s), your driver's license or other form of photo identification, and any applicable co-pay or deductible amounts. Please arrive fifteen minutes prior to your appointment time so that we may enter all your information into our computer system. We are often asked if insurance will cover annual exams, pap smears, labs, etc. Because policies vary so widely depending on the coverage purchased by you or your employer, we have no way of knowing the answers to these questions. Please contact your insurance company directly.

Patients are requested not to use perfumes or other fragrances when coming to the office. Also, we feel it is best that young children not accompany you because of the personal nature of the visit. Please try to schedule your appointments when you are free to concentrate your attention on your visit.

If you are unable to keep your appointment with us, you must notify our office at least 24 hours in advance. Failure to give 24 hours notice will result in a missed appointment fee of at least \$25.00. In addition, our office charges a fee for a replacement prescription, should you lose your original that is given to you at the time of your appointment.

Our office hours are 8:30 a.m. to 5:00 p.m. Monday through Friday. Our staff is available to take your phone calls between the hours of 9:00 a.m. to 5:00 p.m. Monday through Friday. Our office is at 719 Green Valley Road, Suite 101, two buildings down the street from Women's Hospital.

Please call if you have any questions. We look forward to participating in your health care needs.

Sincerely,

Appointment Secretary

719 Green Valley Road, Suite 101 • Greensboro, NC 27408

Phone: 336.370.0277

www.gsowhc.com

Fax: 336.333.9757

Name _____ NCDL # _____

Address _____ Home Phone # _____ Cell Phone # _____

City _____ State _____ Zip Code _____ Date of Birth _____

Email Address _____ Soc Security # _____

Status (circle one): Married Single Separated Divorce Widowed Partnered

Patient Employer _____ Employer Phone # _____

Employer Address _____ Occupation _____

City _____ State _____ Zip Code _____

Emergency Contact Person _____ Relationship _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Responsible Party _____ Relationship _____

NCDL # _____ Soc Security # _____ Home Phone # _____

Address _____ Cell Phone # _____

City _____ State _____ Zip Code _____

Employer _____ Employer Phone # _____

Please present insurance card(s) and complete this section. We will verify your insurance coverage upon your arrival.

Primary Insurance Company _____

Certificate or ID# _____ Group# _____

Policyholder's Name _____ Date of Birth _____ Soc Security # _____

Patient's Relationship to card holder (circle one): Self Spouse Child Other

Policyholder's Employer _____ Work Number _____

Secondary/Supplemental Insurance Company _____

Certificate or ID# _____ Group# _____

Policyholder's Name _____ Date of Birth _____ Soc Security # _____

Patient's Relationship to card holder (circle one): Self Spouse Child Other

Policyholder's Employer _____ Work Number _____

Co-Pays and/or fees for professional services are payable at the time of services rendered. We will be glad to discuss the professional fee with you during regular business hours. If we participate with your insurance carrier, we will file your claim for you. You agree to be responsible for any non-covered services by your insurance carrier, which might be performed by your healthcare provider at Greensboro Women's Health Care, P.A.

Assignment and release: I authorize my insurance benefits to be paid directly to Greensboro Women's Health Care, P.A. I understand that I am financially responsible for non-covered services. I also authorize this practice to release any and all information required to process any insurance claims, and release the information to any other medical provider involved in my health care needs.

Signature _____ Date _____

GREENSBORO WOMEN'S HEALTH CARE, P.A.
FINANCIAL POLICY

Thank you for choosing Greensboro Women's Health Care as your health care provider. The following is a statement of our Financial Policy that we require you to read, agree to, and sign prior to any treatment.

We are committed to providing you with the best possible care, and we will be glad to discuss our professional fees with you at any time during normal office hours. Your clear understanding of our Financial Policy is important to our professional relationship.

You need to be aware of the provisions of your individual insurance policy. Please bring your current insurance card at each visit, and be prepared to pay any deductible and/or co-pays at that time. We will submit insurance claims to those companies with which we have contracts. For those companies we do not contract with, full payment is required at the time of your visit. In the event your insurance company does not pay your claim within 45 days of your visit, you will have 15 days to pay the balance. Past due accounts of 60 days or more are subject to a finance charge and collection fees. Refunds under \$15.00 will be issued by request; otherwise, the credit will remain on your account to be used at your next visit.

Please be aware that by signing below, **YOU ARE ULTIMATELY RESPONSIBLE** for the timely payment of your account, including all non-covered services. For your convenience, we accept cash, personal checks, MasterCard, Visa, Discover and American Express. A \$30.00 fee will be charged for any returned check. We require a minimum 24 hour notice if you are unable to keep this appointment. Failure to give 24 hours notice will result in a missed appointment fee of at least \$25.00.

If you have any questions about the above information or any uncertainty regarding our policy, please feel free to ask us. We are here to help you!

Confidentiality Statement: Greensboro Women's Health Care will protect your confidential information following our Notice of Privacy Practices & Guidelines.

Assignment and release: I have read the above information, and understand and accept the conditions described. I also authorize Greensboro Women's Health Care, P.A. to release information acquired during my examination, or treatment, to my insurance company(ies), and to any other physician(s) involved in my care. This may be revoked at any time by written request.

I have read, understand, and accept the above terms and conditions of the Financial Policy of Greensboro Women's Health Care, P.A. I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to Greensboro Women's Health Care, P.A. representing my medical provider or supplier.

Patient Printed Name

Date

Patient / Responsible Party Signature

HIPAA Notice of Privacy Practices

Effective March, 2010



719 Green Valley Road, Suite 101 • Greensboro, NC 27408

Phone: (336) 370-0277

www.gsowhc.com

Fax: (336) 333-9757

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.



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ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Greensboro Women's Health Care, PA's Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Printed Name

Date

Patient / Responsible Party Signature

Greensboro Women's Health Care, PA

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Greensboro, NC 27408

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*Cynthia P. Romine, MD
Deborah S. Leonard, CNM*

*M. Suzanne Miller, MD
Patty Grubb, FNP*

Thank you for choosing GWHC for your health care. We will do everything we can to partner with you in meeting your health care needs.

We would like to notify you of our missed appointment policy, to avoid any misunderstandings in this regard.

We consider a missed appointment one that you fail to keep without giving us at least 24 hours notice.

The fee is \$25 each time you miss an appointment without giving us 24 hours notice.

For procedures and ultrasounds, the no show fee is \$50. If you also have a sonohystogram scheduled with your pelvic ultrasound, the fee is \$75.

We understand that emergencies happen, and we will consider true emergencies on a case by case basis.

If you wish to do so, you may reschedule a missed appointment after paying the no show fee. However, if you repetitively miss your appointments, you may be asked to seek care elsewhere.

Thank you for understanding the need for such a policy.

Patient Signature

Date