

Greensboro Women's Health Care, PA

719 Green Valley Road, Suite 101

Greensboro, NC 27408

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M. Suzanne Miller, MD
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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 financial policy form. Please complete these forms and **bring them with you at the time of your appointment.** Be sure to bring your current insurance card and any applicable co-pay or deductible amounts. Please arrive fifteen minutes prior to your appointment time so that we may enter all your insurance information into our billing 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, please give our office 24 hour notice to avoid a fee. 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 office is located in the Prudential Carolinas Building, directly across 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

PATIENT DEMOGRAPHICS FORM:

GREENSBORO WOMEN'S HEALTH CARE

PLEASE PRINT

Date

Name _____ Driver Lic. # _____ Soc. Security # _____
 Address _____ Home Phone # _____ Cell Phone # _____
 City _____ State _____ Zip Code _____ Date of Birth _____
 Status: (circle one) Married Single Separated Divorce Widowed Partnered
 Patient Employer _____ Phone# _____
 Employer Address _____ Occupation _____
 City _____ State _____ Zip Code _____

Spouse or Emergency Contact Person _____ Relationship _____
 Home Phone# _____ Work Phone# _____ Cell Phone# _____

Person Responsible for Payment _____ Driver Lic.# _____
 Relationship _____ Social Security# _____ Home Phone# _____
 Address _____ Cell Phone # _____
 City _____ State _____ Zip Code _____
 Employer _____ Work Phone# _____

Primary Insurance Company _____
 Certificate or ID# _____ Group # _____
 Policyholder's Name _____ Birthdate _____ Social Security# _____
 Patient's Relationship to card holder: Self Spouse Child Other
 Policyholder's Employer _____ Work Number _____
 Secondary/Supplemental Insurance Company _____
 Certificate or ID# _____ Group # _____
 Policyholder's Name _____ Birthdate _____ Social Security# _____
 Patient's Relationship to card holder: 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 my insurance claims, and release the information to any other medical provider involved in my health care needs.

Signature _____ Date _____

PLEASE SEE OTHER SIDE

FINANCIAL POLICY

Thank you for choosing Greensboro Women's Health Care, P.A. 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. 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, AMEX, Discover and Visa. A \$30.00 fee will be charged for any returned check. Except in cases of emergencies, we require a minimum 24-hour notice if you cannot keep your scheduled appointment. We reserve the right to charge for appointments cancelled or broken within 24-hour advance notice.

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.

Signature: _____ Date: _____

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336-370-0277

PATIENT PRIVACY NOTICE

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.

We respect our legal obligation to keep private the health information that identifies you. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you: testing or your examination, prescribing medications and faxing them to be filled; referring you to another doctor or clinic for care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health care plans, or other sources of payment: preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" means those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

We will ask for special written permission in the following situations: release of Protected Health Information related HIV status, mental health or treatment for substance abuse.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;

- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosures to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of information that does not identify you by name;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for use and who commit to respect the privacy of your health information;

Only upon your written permission, or verbal permission in extreme situations, will we share relevant information about your care with your family or friends who are helping you with your care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we may mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation, you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocation must be in writing. Send the revocation request to the office manager at the address listed above.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office manager at the address listed at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E Mail to your personal E Mail address. We will accommodate this request if it is reasonable, and if you pay us an extra cost, if we determine the practice to have additional expenses due to your request. If you want to ask for confidential communications, send a written request to the office manager at the address at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally avoidable. By law, we can have one 3-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office manager at the address shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law, we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office manager at the address listed at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office manager at the address shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this Notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office manager at the address listed at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office manager at the address listed or phone number shown at the beginning of this Notice.

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**ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY POLICIES**

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

