

Lexington Women's Health • 1720 Nicholasville Road, Suite 702 • Lexington, KY 40503

PATIENT INFORMATION

**PLEASE SIGN AND DATE REVERSE SIDE*

Patient's Last Name	First	MI	Sex	Birth Date	Social Security #	Home Phone #
			M F			()
Mailing Address			City, State, and Zip		Cell Phone #	
Patient's Employer (If Applicable)			Spouse/Parent(s) Name			Spouse's Birth Date
Business Phone ()						
Spouse's Employer (Include City and State)					Business Phone	
					()	
In Case of Emergency Contact:			Relationship		Phone #	
					()	
Who May We Discuss Your Health Information With?						
No One Other Than Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other - Name _____						
May we leave messages/or send email regarding your health information on your voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes email						
Referred by: _____			PCP: _____			

MEDICARE PATIENTS ONLY (Required by Medicare Program)

Are you or your spouse covered by an Employer Group Health Benefit Plan? ___ YES ___ NO
 Are you or your spouse working for an employer with more than 20 employees? ___ YES ___ NO
 Do you receive Black Lung Benefits? ___ YES ___ NO
 Do you receive workers comp benefits? ___ YES ___ NO
 Are you being seen for an injury or illness for which another party could be held liable or is covered under Automobile No fault insurance? ___ YES ___ NO

CHECK POLICY

We accept checks:

For your convenience if your check is dishonored, or returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of \$50.00

INSURANCE INFORMATION - PLEASE PRESENT CARD TO RECEPTIONIST

CONSENT

I hereby consent to Lexington Women's Health (the "Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Specific Records Expressly Included. I expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information. (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE:	
<input type="checkbox"/> Chemical Dependency/Substance Abuse	
<input type="radio"/> Drugs	<input type="radio"/> Alcohol
<input type="checkbox"/> Sexually Transmitted Diseases	

FINANCIAL

Our main goal is providing you the best care and service. We also recognize the need for a clear understanding of your financial obligations for the treatment you receive. In order to create a better understanding between patients and our practice, we have adopted the following policy. If you have any questions about this policy, we encourage you to contact our patient accounts department.

PATIENTS WITHOUT INSURANCE COVERAGE:

Unless prior arrangements have been made with the Patients Accounts Manager, payment in full is due on the day of service. For your convenience, we accept cash, checks, Visa and MasterCard. We do not charge interest on unpaid balances; therefore, we cannot extend credit for more than 90 days. This provides you with sufficient time to secure outside financing through a lending institution such as a bank or finance company in order to make extended payments to fit your personal budget.

RETURNED CHECKS:

Due to the expense of processing checks returned by the bank, we charge a \$25.00 service fee. Any returned check must be paid within ten (10) days or it may be turned over to a collection agency or the County Attorney's Office.

INSURANCE CLAIMS:

We participate with numerous insurance plans and will gladly file your claim for you. Co-payments are due on the day of service. This is generally required by your insurance plan as part of our contract with them. For insurance plans with whom we are not a contracted provider, we will gladly file your claim for you. Benefits will be assigned to us which means payment will be made directly to our office. A \$10 billing fee will be applied to your account if your co-pay is not paid at the time of service.

ADULT STUDENTS COVERED BY PARENTS INSURANCE:

We will gladly file your claim for you. However, if you are over the age of 18, you are responsible for your bill. All co-payments are due on the day of service. We will need your current address and your permanent billing address for our files.

PRIVACY:

I have been offered and/or received a copy of Lexington Women's Health Notice of Privacy Practices.

AUTHORIZATIONS

I hereby give my permission to Lexington Women's Health for the evaluation and treatment of the presented condition.

I hereby authorize the above physician(s) to release information regarding services rendered by him/her and allow a photocopy of my signature to be used to file insurance.

I hereby authorize the physician(s) indicated above to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign all payments for medical services rendered.

I have read the financial, consent and privacy policy statements for Lexington Women's Health on the reverse of this page and agree to the terms herein. I also understand that such terms may be amended when needed by the practice.

Patient or Responsible Party

Date