TOTALCARE FOR WOMEN: 667 Kingsborough Square #200, Chesapeake, VA 23320
700 Independence Circle, Suite 1-D, Virginia Beach, VA 23455
1141 N Road Street, Suite I, Elizabeth City, NC 27909
109 Currituck Commercial Drive, Moyock, NC 27958
(757) 436-0167

PATIENT REGISTRATION

Patient Name: ____ **Patient ID:** ____________________

Address: ____

City: ____ **State:** ___________ **Zip:** ____________

Phone: ___________________________ **Cell:** ___________________________ **Emergency:** ____________________

Patient DOB: _________________________ **Patient Age:** _____________ **Patient Sex:** ____________________

Patient SSN: _______________________ **Marital Status:** _________________________

Email: ____ **Preferred Method of Contact:** ___________________

Race: _ American Indian _ Asian _ Black _ Chinese _ Filipino _ Pakistani _ Vietnamese
_White _ Other: __________________ _ Declined

Ethnicity: _ Central American _ Cuban _ Dominican _ Hispanic / Latino _ Latin American _ Mexican
_ Not Hispanic or Latino _ Puerto Rican _ South American _ Spaniard _ Declined

Language: _ English _ Other: _________________

GUARANTOR'S INFORMATION

Guarantor's Name: ____

Guarantor's DOB: _________________________ SSN: _________________________

Address: ____

City: ____ State: ___________ Zip: ____________

Access Allowed to Patient Portal __ Yes __ No

EMERGENCY CONTACT

Emergency Contact Name: ____

Phone: ___________________________ Emergency Contact Relation: ______________________________

PATIENT'S EMPLOYMENT

Name of Employer: ____ Phone: ______________________________

Address: ____

City: ____ State: ___________ Zip: ____________

Insurance Changes _ Yes _ No

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 physicians, including but not limited to blood and urine tests, drug tests, and any other procedures or treatment. I agree to allow TotalCare for Women, PLC to obtain medication history. I authorize the release of all medical records to the referring and family physicians, if applicable. I authorize the release of medical information to process my claims, and authorize TotalCare for Women, PLC direct receipt of insurance payment for services rendered. I allow fax transmittal of all my medical records, if necessary. I further acknowledge that I have been provided with a copy and given the opportunity to review the Notice of Privacy Practices of Mid-Atlantic Women's Care pursuant to the Federal regulations known as HIPAA privacy rules.

_______________________________________ _______________________________________
Signature of Patient or Responsible Party Date

_______________________________________ _______________________________________
Printed Name Relationship to Patient

Candice Geary, M.D.
Paul Lindner, M.D.
Paul Moncla, M.D.
Steven Powers, M.D.

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NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the bodily fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies. Pursuant to this provision, the testing would be explained and you would be given the opportunity to ask any question you might have.

Whenever any patient is indirectly exposed to bodily fluids of health care Provider, or of any person exposed by or under the direction and control of health care Provider, in a manner which may according to the then current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus. Such person shall also be deemed to have consented to the release of such test results to the patient who was exposed.

I have read and understand the above "Notice of Deemed Consent to HIV Blood Testing".

____________________________________ ____________________________________
Patient's Printed Name Date

____________________________________ ____________________________________
Signature of Patient or Responsible Party Witness

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CONSENT TO OBTAIN MEDICATION HISTORY

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR / EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and / or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

___________________________________ ___________________________________
Signature of Patient or Responsible Party Date

___________________________________ ___________________________________
Printed Name Relationship to Patient

By signing this consent form, you are giving your healthcare provider permission to collect, and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS / HIV and medicines used to treat mental health issues such as depression.

Pharmacy Name: ____

Location: ____

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents or others to call and discuss medical information, request prescriptions, appointment information, medical records, test results, or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I, ____(DOB: ___________________) , authorize TotalCare for Women, PLC to release my health record of the following information:

___ Complete Chart (note: this gives the recipient full access to your health record)

OR

___ Limited Access (please check which of the following items to share with recipient)
___ Lab / Pathology Results
___ Ultrasound / Radiology
___ Notes / Visits
___ Prescriptions / Medications
___ Insurance / Billing Information
___ Appointments

To the following recipients (please print clearly):

Name: _______________________________________ Relationship to Patient: __________________________

Name: _______________________________________ Relationship to Patient: __________________________

Name: _______________________________________ Relationship to Patient: __________________________

By signing this form I understand this information may only be made available from the date of my signature and up to one year thereof. I understand I have the right to revoke this authorization in writing at any time.

______________________________________ ______________________________________
Signature of Patient or Responsible Party Date

______________________________________ ______________________________________
Witness Date

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OFFICE FINANCIAL AND PAYMENT POLICY

Thank you for choosing TotalCare for Women, PLC as your healthcare provider. We are committed to providing you and your family with the best possible medical care. In our ongoing process to make sure all of your medical needs are met, we would like to present our Office Financial and Payment Policy in order to minimize misunderstanding about fees. We ask that all responsible parties read and sign this policy prior to seeing the physician. This policy is offered in an attempt to develop and sustain a continued professional and pleasant relationship. Our billing department will be available to discuss our fees and this policy with you.

As a courtesy to you, TotalCare for Women, PLC will bill your insurance carrier for services provided. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any changes of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Any laboratory tests which require an outside lab to perform will be billed separately by that company.

As the responsible party, please understand (INITIAL EACH OF THE FOLLOWING):

____ 1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charge. As your medical provider, we will only supply factual information to facilitate claim processing.

____ 2. We advise that you familiarize yourself with the benefits of your insurance plan. Certain health insurances require that you obtain a referral or prior authorization from your Primary Care Physician before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

____ 3. Payments for all services, which include unpaid balances, deductibles, co-payments, or other non-covered services as set by your insurance carrier are due at the time services are rendered. In order to service you better, we accept cash, check, Visa, MasterCard, and Discover.

____ 4. Returned checks will be subject to a fee of $35.00.

____ 5. Office appointments that are cancelled within 24-hour notice or failure to present for appointments scheduled are subject to a $25.00 charge. Surgeries that are cancelled within 48-hour notice or failure to present for procedure scheduled are subject to a $250.00 charge.

____ 6. All charges are your responsibility whether your insurance company pays or does not pay. If the account is not paid in full within sixty days of service, interest at the rate of 1% per month (12% APR, minimum $2.50 per month) may be assessed on the aged balance. If any payment is made directly to you for services billed by TotalCare for Women, PLC, you recognize an obligation to promptly remit payment to TotalCare for Women, PLC.

____ 7. I understand that if I fail to make any of the payments for which I am responsible in a timely manner and my account becomes delinquent, I agree to be responsible for any and all cost of collecting monies owed. This is including, but not limited to, court costs, litigation costs, and attorney's fees of 35% associated with any necessary collection procedures brought about by TotalCare for Women, PLC, should that be necessary. We reserve the right to turn any account that becomes delinquent over to a collection agency or attorney's office who would then manage the collection of your account.

At TotalCare for Women, PLC, we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us so that we may assist you in keeping your account in good standing. If you have any questions, please contact our billing department at (804) 486-7008.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW.

______________________________________ ______________________________________

Signature of Patient or Responsible Party Date

______________________________________ ______________________________________

Printed Name Relationship to Patient

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Definition of a Routine Well-Woman Visit

The focus of a well-woman visit is preventive care. If tests or services beyond the scope of a well-woman visit are provided, then additional charges may be incurred for those services. The choice to address both well care and medical issues are offered for the convenience of avoiding two visits; however, you may owe a copayment, coinsurance, or deductible for this additional service. Although our office will assist you with your insurance processing, it is the patient's responsibility to understand their insurance benefits and to ensure they are eligible prior to scheduling their annual wellness exam.

What is included in a Well-Woman Visit?

Yes	No
• A review of your current health and medical history • Counseling about ways to improve your health choices, such as your smoking and drinking habits, your food choices, and exercise routines • A general physical exam, including height, weight and blood pressure assessments, a clinical breast exam, an age appropriate pelvic exam to check your abdomen, pelvis, vulva and vagina for any abnormalities • Pap smear when appropriate with Human Papilloma Virus (HPV) screening • Counseling on family planning and contraceptive methods • Immunizations and screening tests, if needed (some insurances will not cover these services)	• Additional testing or treatment for a specific health concern or condition • Services ordered due to current symptoms that require further diagnosis • Follow up from previous visits that require further testing • Lab work, ultrasounds, or additional tests related to a specific health concern or condition

Your scheduled appointment today is for a well-woman visit. Each insurance company has different rules regarding coverage for preventive care. If tests or services beyond the scope of a well-woman visit are provided, then you may incur additional charges that are required to be paid at checkout, if not collected at check-in.
If you are uncertain of your coverage, please contact your insurance company regarding benefits.

_____________________________________ _____________________________________
Patient's Printed Name Date

_____________________________________ _____________________________________
Signature of Patient or Responsible Party Witness

____
Patient's Date of Birth