WOMEN'S TOTAL HEALTH,LLC
Fred Nichols, D.O.
Cara Mia Konzel, MS, RN, APN

Welcome to Women's Total Health **Please sign back of this form**

Date:	Patient Last Name, First Name & Middle Initial	Date of Birth	Age	Social Security Number

Patient Mailing Address (please include apartment number if applicable)

Town State Zip

Patient Home Number	Patient Work Number	Patient Cell Number

Please indicate preferred contact number ☐ Home ☐ Work ☐ Cell	E-mail id	Preferred Language:

Patient Gender: ☐ Female ☐ Male	Patient is ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other	Patient Relationship To Policy Holder ☐Self ☐Spouse ☐Child ☐Other

Race:
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ White ☐ Other ☐ Prefer not to answer

Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Prefer not to answer

Name of **Primary** Insurance Carrier	Member ID#	Group Number

Policy Holder Name- Last Name, First Name	Policy Holder Date of Birth (Required)	Specialist Copay

Name of **Secondary** Insurance Carrier	Member ID#	Group Number

Policy Holder Name on Secondary Plan	Policy Holder Date of Birth (Required)	Specialist Copay

Reason for this visit ☐Well-Woman ☐Illness/Problem ☐Pregnancy ☐Other	Participating Lab(Required)	Previous OB/GYN physician:

Primary Care Physician	Preferred Pharmacy	Town

How did you hear of us?
☐ Doctor Name:_____

☐ Family/Friend ☐ Insurance ☐ Internet ☐ Returning Patient ☐ Social Media ☐ Street Sign/Ad ☐ Yellow Pages

Emergency Contact	Telephone Number	Relationship

Name & address of nearest relative not living with you	Telephone Number	Relationship

I understand I have the right to request a chaperone during a medical exam which may include a breast and pelvic examination. I understand if I would like a chaperone present, I must request this to your medical staff at every visit. I acknowledge and understand my right to request a chaperone at any time.

Patient Signature_____ Date_____

I acknowledge receipt and understand the HIPAA privacy laws as they pertain to Women's Total Health.

Patient/Guardian Signature_____ Date_____

I authorize Women's Total Health and staff to leave messages at my home, via writing and voice regarding my medical care.

Patient/Guardian Signature_____ Date_____

I authorize the following person to receive information regarding my medical care.

Name :_____Tel# _____ Relationship_____

Patient/Guardian Signature_____ Date_____

*Must be 18 Years of age to sign HIPAA policy.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN WHERE INDICATED

RELEASE & ASSIGNMENT OF BENEFIT

- I authorize the release of any and all information necessary to secure the payment of benefits submitted for services rendered by Women's Total Health, on behalf of myself and/or dependents. Information will be given to our contracted billing service, Advanced Electronic Medical Billing, Inc. to secure payment. I agree that my signature on this document authorizes claims to be submitted for benefits without obtaining my signature on every claim form, and this authorization has no expiration. I assign directly to Women's Total Health, LLC insurance payments for all services. I also authorize Women's Total Health & billing agent, to file a complaint on my behalf regarding reimbursement.

FINANCIAL POLICY

- **I understand I am financially and fully responsible for all charges incurred if my insurance carrier denies payment for any reason.** I understand I will be financially responsible for any deductibles, coinsurance or co-pays according to my benefit plan. I understand a co-payment is due at the visit. I understand a delinquent balance must be paid in full prior to any scheduled appointments, unless prior payment arrangements are made. I understand I am responsible for contacting my insurance company prior to services rendered, to determine if the provider participates with my plan, determine if any referral or pre-authorization is needed, and understand coverage limits. I agree and understand that this office can only code and file a claim for my visit with a diagnosis that was encountered/documented in my medical record. In the event my insurance carrier sends payment to me, I agree to pay Women's Total Health the same amount in addition patient out of pocket due. I agree to send in a check along with the explanation of benefits upon receipt of payment. I agree to provide Women's Total Health with current insurance information and changes within 30 days from the visit date. I understand that if a claim is not paid due to my failure to provide correct insurance information in a timely manner, I am responsible for the charges. I understand payment is due upon receipt of invoice. Statements will reflect the amount due and description of services provided. I will be responsible for returned check fees. All credits will remain on file and applied to future balances owed, unless a refund is requested in writing. I may be charged a $50.00 fee if an appointment is missed/cancelled without 24 hour notice.

- A well woman exam preventative visit includes a medical history, physical exam & testing to screen for asymptomatic diseases & renewal of maintenance medications. Per coding guidelines, an additional service may be billed if a medical problem and/or counseling is addressed requiring additional time during your annual exam; a copay may apply. Some insurance carriers pose benefit limits for routine visits and/or contraceptive management. I may be responsible for these charges.

- **COLLECTION ACTIONS**
  In the event my account is referred to collections because of an unpaid balance, I hereby agree and promise to pay between 25-35% of the balance due and owing, applied at the time of placement with our attorney or collection agency. I will also be responsible for any additional fees such as, but not limited to, filing fees, court fees or other administrative collections fees due upon payment of collection balance.

- **MEDICARE ADVANCE BENEFICIARY NOTICE OF COVERAGE LIMITS**
  A screening pap smear and pelvic examination (including clinical breast examination) are covered by Medicare every 2 years. Annual coverage is only allowed for a screening pelvic and pap smear in those women considered high risk as defined by Medicare guidelines. If Medicare denies payment for the screening, I understand that I will be financially responsible for payment for any non-covered services.

PATIENTS UNDER THE AGE OF 18

- If an insurance card is presented a claim will be filed. An insurance carrier may send an explanation of benefits with detailed information to the insured. If the insurance company states payment is due from the subscriber or patient, I understand that an invoice will be sent to the guarantor below containing a description of services provided. I agree you can contact the insured and/or guarantor listed below. I hereby waive any privacy/confidentiality claims that I have against you for notifying the insured and/or guarantor that may be my parent.

This agreement has no term date and will remain in force until such time as a new agreement is signed.

_____

Patient or Guarantor Signature (Must be 18 Years of Age) **Date:**

Please print name:
Please print address & Telephone #: