PATIENT INFORMATION PLEASE COMPLETE FRONT AND BACK ALL LINES

EMAIL ADDRESS ______________________________@__________________

For patient portal access. Please print and write exactly with caps and small case as appropriate) . com or . net, etc…

We encourage you to register for the portal if you have not already done so in order to view your results

(____)__________ (____)__________ EXT #______ (____)__________ MOBILE HM WK

YOUR HOME TELEPHONE # DAYTIME / WORK TEL. # (Confidential VM ? YES NO) YOUR MOBILE # (CIRCLE) PREFERRED CONTACT #)

____ ______ S M W D SEP DP OTHER

LEGAL LAST NAME FIRST MIDDLE MAIDEN RACE (Circle) Marital Status

NAME YOU GO BY______________ ____-____-____ ____/____/____ ______

SOCIAL SECURITY # DATE OF BIRTH AGE

Your Mailing Address STREET NAME APT # CITY STATE ZIP CODE

Physical Street Address Where you reside?______________________________

YOUR OCCUPATION YOUR EMPLOYER BUSINESS ADDRESS

Who is responsible for paying any bill from today? SELF SPOUSE MOTHER FATHER Is their address the same? YES NO

YOUR SPOUSE / PARTNER'S NAME THEIR OCCUPATION EMPLOYER

(____)__________ (____)__________ ____YES____NO____

SPOUSE / PARTNER'S WORK TEL. # SPOUSE / PARTNER'S MOBILE TELEPHONE # Is your partner your emergency contact?

________________________ (____)__________ (____)__________

IF APPLICABLE YOUR ADULT CHILDREN'S NAMES TELEPHONE #'S IF APPROPRIATE

________________________ __________ (____)__________

EMERGENCY CONTACT NAME IF OTHER THAN SPOUSE OR PARTNER RELATIONSHIP THEIR TELEPHONE #

________________________ (____)__________

EMERGENCY CONTACT ADDRESS THEIR MOBILE TELEPHONE #

FROM WHOM DID YOU HEAR ABOUT OUR PRACTICE? ______________________________

E.g. Friend, newspaper, yellow pages, internet yellow pages, internet search, physician referral list, insurance referral list

Communication Consents

I hereby authorize providers and staff of GYN Center for Women, PA to:

Can we have permission to call you? YES NO **Can we send text messages to you?** YES NO

Leave a message on my home answering machine or mobile voice mail with normal test results YES NO N/A

Leave a message on my confidential work voice mail if applicable with normal test results: YES NO N/A

Email me when other methods of reaching me have failed, & with patient portal information? YES NO

Leave upcoming appointments reminders with a family member who may answer my home / mobile phone? YES NO

Can we have your permission to access your Medications History through our e-prescribing feature? YES NO

(This is especially helpful if you ask us for refills and cannot remember names of medications.)

Who is your Primary Care Physician or Internist? ______________________City__________

WHICH PHARMACY DO YOU PREFER? ______________________________

Pharmacy Name Street Name City

If you were referred to us by another doctor, Please provide their Name & Address

__________ ______ (____)______________________

REFERRING DOCTOR'S NAME SPECIALITY TELEPHONE NUMBER ADDRESS CITY

We are happy that you have chosen our office for your medical care.
We welcome any questions or suggestions that you might have.

Please turn over and complete the back side

PLEASE READ THE FOLLOWING IMPORTANT INFORMATION

Payment is expected at time of service. You are responsible for all insurance co-pays, co-insurance amounts and unmet insurance deductible amounts. **All insurance policies** can leave **YOU Responsible** for certain charges and we will bill you for those. If you receive a bill from this office then **Your Insurance Has Paid** and assigned **YOU** as the responsible party for the billed amount. Patients with High Deductible Insurance plans will need to speak with the manager to make payment arrangements today, before you are seen. We do see Self Pay Patients and offer them a discount. We accept cash, credit cards, personal checks and Care Credit.

I understand that if I do not set up a payment plan or pay all of the charges due from me **within 90 days of receiving my first bill** from this office that my account will be sent to an outside collection agency, and an additional fee equal to the collection agency's commission will be added to my outstanding balance. These fees may increase over the time it takes to collect from me. We do not issue refunds on credit balances of less than $5.00. Unused credit balances will only be held for three years on your account.

We reserve the right to reschedule your appointment if you do not present your current insurance card on arrival in our office
There is a records copying charge of $25.00. Payment must be made before records can be copied and released.
There will be a $35.00 charge on all returned checks. There will be a charge of $25.00 for missed appointments and / or last minute cancellations without a 24 hour notice.
There is always a doctor on call after hours. Please call the office for instructions on reaching the doctor on call.

I have read and understand all of the above. ______________________ ____/____/____
Patient Signature **Today's Date**

BILLING INFORMATION IF INSURANCE NOT IN YOUR NAME

Is your Insurance in your name? **YES (SKIP TO THE NEXT SECTION). No** Who is the Primary Insured on the Policy?

Name ______________________ Their Birthdate?____/____/____ Relationship to you?__________ Gender? M F
The Primary Insurance Holder's Name: (husband, or parent etc…)

______________________ **Secondary Insurance Holder** ______________________ DOB____/____/____
Their Address if they are responsible for this bill

AUTHORIZATION TO PAY INSURANCE BENEFITS DIRECTLY TO THE PHYSICIAN

I hereby authorize direct payment from my insurance to Pouru Bhiwandi, M.D. for physician services, I understand that if I do not authorize this, I have to pay in full for services each time I come in

Insured Patient Signature X______________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize release of medical information from Pouru Bhiwandi, M.D. to any insurance company with whom I have medical or surgical benefits. I authorize release of information from Pouru Bhiwandi to any medical facility, hospital or insurance department at my place of employment (Usually only with Employer Administrated Ins. Plans) ONLY for the purpose of filing medical or surgical claims or obtaining medical information for claims processing and payment. **Signature X**______________________

Sharps Injury Consent: If the doctor or an employee of this office were exposed to your blood, tissue, or body fluids, through an accidental needle / sharps stick: I consent to having my blood and / or body tissues and fluids tested by this office at no cost to me to rule out infectious diseases like hepatitis or HIV in my blood. This is done as a protection for the doctor and / or employee.

Your Signature X______________________ **Date** ____/____/____

Acknowledgement that we have offered you a copy of The Notice of Privacy Practices

I acknowledge that I have been offered a copy of Pouru Bhiwandi, MD's Notice of Privacy Practices. (Form available at the front desk at the time of your appointment.) The Notice describes how Pouru Bhiwandi, M.D. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.
We do not release any information without your signed consent. X______________________ **Date** ____/____/____
Signature of Patient, or Personal Representative

Re-attest Dates ________ ________ ________ ________ ________ ________ ________ ________

PUT YOUR CREDIT CARD ON FILE WITH US & MAKE YOUR LIFE EASIER AND RECEIVE FEWER BILLS
You Set your monthly payment Limits & Numbers are Secured

High Deductible Plans: Our current Policy is that we keep your credit card/ FSA/ HSA card on file, with your permission, and automatically bill to your card- your deductible and co-insurance payments up to a limit you set with us. Please acknowledge this policy here. If you want to go ahead and provide us the information speak w/ representative at window. If you end up with a balance after a visit here we will ask you again to put the card on file.

Signature______________________ Date ____/____/____