Name: _____ **DOB:** _____

Release of Information:
Please tell us how you wish to be contacted. Check all that apply.

Contact Phone # _____

OK to leave a message with detailed information ___Leave message with call back number _____

Please tell us with whom we are allowed to discuss and/or disclose your personal health information:

Circle all that apply: Spouse Adult Children Parents Sibling Personal Representative

Name(s) of above: _____ Phone #: _____

_____ Phone #: _____

Reason for today's visit:

Routine GYN/Pap smear _____ Prenatal care _____ New Obstetrical Care _____

Other _____

Date of last menstrual period: _____

The reasons listed above for today's visit will help us bill your insurance company properly and accurately. We will not change your diagnosis (because it is considered fraud) if your insurance company does not cover any of the services rendered today.

If you have questions about your lab bill, please do not call this office. Call your lab or your insurance carrier directly.

I have received/read Notice of Privacy Practices (This is my written acknowledgement).

Signature of Patient: _____ Date: _____

NOTICE TO ALL PATIENTS:

- I acknowledge and understand I am responsible for the charges for all of the services rendered to me or any member of my family.
- I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Chesapeake Women's Care, P.A.
- I clearly understand it is my responsibility to make sure the bill is paid within sixty days. If, for any reason, any portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt payment of the bill.
- If, for any reason, my insurance coverage is dropped or cancelled at any point, I hereby agree to pay promptly upon receipt of the monthly statement.
- Despite the type of insurance I have, I understand CWC requires my signature to keep on file.
- There is a $25.00 charge for returned checks. Accounts not paid in full after 120 days will be forwarded to our collection agency. I understand that I am responsible for charges associated with the collection process added to my account.
- I understand that, if I request any documents to be emailed or faxed to me, this is not a secure process. Also, there may be charges associated with the transfer of medical records.

Signature of Patient: _____ Date: _____