

WOMEN'S TOTAL HEALTH, LLC
Fred Nichols, D.O.

Welcome to Women's Total Health. Your assistance in completing this form is appreciated. Please sign back of this form.

Date:	Patient Last Name, First Name & Middle Initial	Date of Birth	Age	Social Security Number
Patient Address (please include apartment number if applicable)				
		Town	State	Zip
Patient Home Phone Number		Patient Cell Number		Work Number
Patient Relationship To Insured		Patient is		E-mail id
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other		
POLICY HOLDER INFORMATION - *THIS SECTION MUST BE COMPLETED*				
Insured Name- Last Name, First Name & Middle Initial			Insured Date of Birth (Required)	
INSURANCE INFORMATION - *THIS SECTION MUST BE COMPLETED*				
Name of Primary Insurance Carrier		Member ID#		Group Number
Address of Primary insurance carrier		Name of Participating Laboratory (Required)		
Name of Secondary Insurance Carrier		Member ID#		Group Number
Insured Name on Secondary Plan		Insured Date of Birth (Required)		
Reason for this visit				
<input type="checkbox"/> Well-Woman Exam <input type="checkbox"/> Illness/Problem <input type="checkbox"/> Pregnancy				
Name of Primary Care Physician			How did you hear of us?	
Emergency Contact		Telephone Number		Relationship
Pharmacy		Town		
Name & address of nearest relative not living with you		Telephone Number		Relationship
<p>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.</p>				
Patient Signature_____			Date_____	
<p>I acknowledge receipt and understand the HIPAA privacy laws as they pertain to Women's Total Health.</p>				
Patient/Guardian Signature_____			Date_____	
<p>I authorize Women's Total Health and staff to leave messages at my home, via writing and voice regarding my medical care.</p>				
Patient/Guardian Signature_____			Date_____	
<p>I authorize the following person to receive information regarding my medical care.</p>				
Name:_____		Relationship_____		
Patient/Guardian Signature_____			Date_____	
*Must be 18 Years of age to sign HIPAA policy.				

- I authorize the release of any and all information necessary to any entities to secure the payment of benefits submitted for services rendered by Women's Total Health, on behalf of myself and/or dependents. Information is provided to a contracted billing service, Advanced Electronic Medical Billing, Inc. to secure the payment of benefits. I further 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 and financial agreement has no expiration. I assign directly to Women's Total Health, LLC insurance payments for all services rendered. I also authorize Women's Total Health and their billing agent, to file a complaint on my behalf for any dispute/appeal regarding reimbursement.
- **I understand I am financially and fully responsible for all charges incurred if my insurance carrier denies payment for any reason.** I will be financially responsible for services deemed patient responsibility per my insurance carrier. I understand that a copay is due at the time of service. A delinquent balance must be paid in full prior to any scheduled appointments, unless prior arrangements are in place. I am responsible for contacting my insurance company prior to services rendered, to determine provider participation, referral, pre-authorization requirements, and coverage limitations. Our office can only code & file a claim for my visit with a diagnosis that was encountered/documentated in my medical record. In the event my insurance carrier sends payment to me, I agree to reimburse Women's Total Health the same amount in addition to patient responsibility owed. I agree to send in a check upon receipt of payment. I agree to provide Women's Total Health with current insurance information and notify 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, I am responsible for the charges. Payment is due upon receipt of my statement. All statements will include a description of services provided. I will be legally responsible for all collection costs involved including attorney's fees that are 1/3 of all balances due and owing, collection filing fees, & returned checks fees. All credits will remain on file and applied to future balances owed, unless a refund is requested. I may be charged a \$50.00 fee if an appointment is missed/cancelled without 24 hours 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. Some insurance carriers pose benefit limits for routine visits and/or contraceptive management. I may be responsible for these charges.
- **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 at 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 insurance is presented a claim will be filed. An insurance carrier may send detailed information to the insured. If there is a balance due I understand that an invoice will be sent to the guarantor below containing a brief description of services provided. I agree you can contact the insured and/or guarantor 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. If no insurance coverage exists payment is due in full at the visit. Patient under age of 18 Signature: _____

A SIGNATURE ACCEPTING FINANCIAL AGREEMENT IS REQUIRED BELOW.

Patient or Guarantor Signature (Must be 18 Years of Age)	Date:
Please print name:	
Please print address & Telephone #:	