NEW PATIENT REGISTRATION FORM

PLEASE PRINT WHEN COMPLETING THIS FORM

Today's date:			
PATIENT INFORMATION			
Patient's First Name/Middle Initial/Last Name: Date of Birth:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow
Email address:			
Address (Street /P.O. Box, City, State, Zip Code):			
Social Security No.:			
Home Phone No / Cell Phone No:			
Employer Name:	Employer Phone No:		
Occupation:			
Primary Care Provider (Family Doctor):			
Race: White American Black or African American Native American Alaskan Native Asian American Native Hawaiian			
Ethnicity: Hispanic or Latino Not Hispanic or Latino			
Preferred Language: English Spanish			
PHARMACY INFORMATION			
Pharmacy Name & Location:			
PERSON RESPONSIBLE FOR ACCOUNT AND INSURANCE INFORMATION			
Person responsible for bill (First Name, Middle Initial, and Last Name):			
Address (Street, City, State, Zip Code):			
Home Phone No. / Cell Phone No.:			
PRIMARY INSURANCE INFORMATION			
Name of Insurance:			
Policy ID No.:			
Group No.:			
Employer:			
Name of Policy Holder:			
Social Security No.:	Date of Birth:		
Policy Holder Relation to Patient: Self Spouse Child Other (Circle one)			
SECONDARY INSURANCE INFORMATION			
Name of Secondary Insurance (if applicable):			
Policy ID No. (if applicable):			
Group No. (if applicable):			

Group Employer (if applicable):

Name of Policy Holder (if applicable).

Social Security No.: Date of Birth:

OFFICE INFORMATION

How did you hear about Women's Center at Westover Hills?

Family Friend Co-Worker Health Plan/Insurance Directory ZOC DOC Movie Theatre Physician (Please circle)

Doctor or person who referred you:

CANCELLATIONS / RESCHEDULES

If you need to cancel or reschedule an appointment, we ask that you give at least 24 hours' notice if possible. This allows us to manage our office schedule more efficiently, and also makes it possible to see a patient who has an acute problem, but might otherwise have been unable to get an appointment on that day. No appointments will be rescheduled after regular office hours. Our answering service is unable to see our schedules. Three or more such occurrences may be cause for termination of care through our office.

CHILDREN POLICY

As parents and obstetricians, we adore children. As your physician, we are concerned about typical childhood diseases and the health effects they could have with other patients, expectant mothers and their unborn child. Bringing small children into the office can also expose them to biohazardous material. We ask that you make childcare arrangements for your children prior to your office visit. Newborns may come with you at the postpartum visit. We deeply understand the inconvenience that this may cause. However, the health and safety of all our patients must be our primary concern.

Signature of Patient / Date

IN CASE OF AN EMERGENCY

Name of local friend or relative (not living at same address):

Relationship to Patient:

Home Phone No. / Cell Phone No:

Work Phone No.:

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

Patient / Guardian Signature: (Please sign above) Date:

Women's Center Representative: (Please sign above) Date:

NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

Women's Center at Westover Hills uses health information about your treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of Women's Center at Westover Hills. How Women's at Westover Hills used health information about your treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of Women's Center at Westover Hills.

How Women's Center at Westover Hills May Use or Disclose Your Health Information

For Treatment. **Women's Center at Westover Hills** may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. Women's Center at Westover Hills may use your health information when referring you to other health care professionals and facilities.

For Payment. **Women's Center at Westover Hills** may use and disclose your health information to others for purpose of receiving payments for treatment and services that you receive. For example, a bill may be sent to you, your insurance policy holder, or third-party payers such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment of supplies used in the course of treatment.

Women's Center at Westover Hills may use your information to contact your about your account balances. Women's Center at Westover Hills may use your information to access financial assistance programs for you that may help to defray the cost associated with your care of treatment.

For Health Care Operations. **Women's Center at Westover Hills** may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and other to:

- ✓ Evaluate the performance of our staff.
- ✓ Assess the quality of care and outcomes in your case and similar cases.
- ✓ Learn how to improve our facilities and services; and
- ✓ Determine how to continually improve the quality and effectiveness of the health care we provide.

Required by Law. Women's Center at Westover Hills may use and disclose information about you as required by law. For example, Women's Center at Westover Hills may disclose information for the following purpose:

- ✓ For judicial and administrative proceedings pursuant to legal authority
- ✓ To report information related to victims of abuse, neglect or domestic violence
- ✓ To assist law enforcement officials in their law enforcement duties

Appointment Reminders and Treatment Calls. Women's Center at Westover Hills may contact you to provide appointment reminders or information about treatment plans, medication or test results, other health-related benefits and services that may be of interest to you. When contacts are made via telephone, messages will be left on answering machines with limited information.

Notification. Women's Center at Westover Hills may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family. Women's Center at Westover Hills professional staff, exercising their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Miscellaneous Communications. Women's Center at Westover Hills may occasionally use your information to send you notice or other written communications. We may also use your information to identify candidates for focus groups to improve the quality of service for our patients.

Public Health. Your health information may be used for disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Descendants. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for organ or tissue donation purposes.

Physician Board Certification. Women's Center at Westover Hills may use your health information to submit to the Professional Certification Board for purposes required for physician's qualifications to complete their specialty board examination.

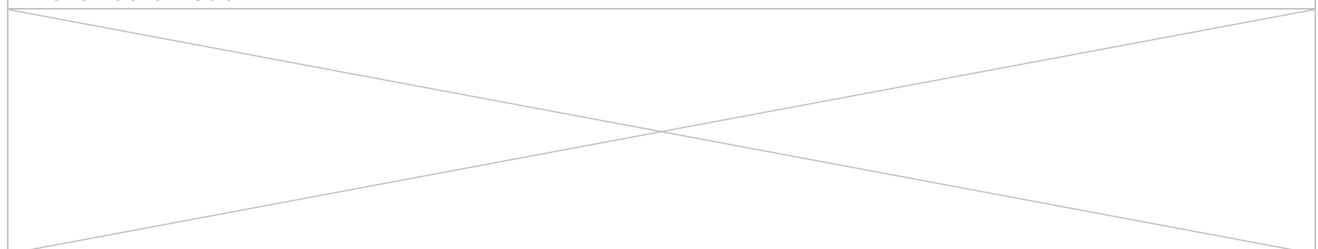
Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you and any other person pursuant to applicable law.

Food and Drug Administration (FDA). Women's Center at Westover Hills may disclose to the FDA health information relative to adverse events with respect to food, supplements, produce and product.

Government Functions. Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Other Uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent Women's Center at Westover Hills has taken action in reliance on such.



YOUR HEALTH INFORMATION RIGHTS

YOU HAVE THE RIGHT TO:

- ✓ Request a restriction on certain uses and disclosures or your information; however, Women's Center at Westover Hills is not required to agree to a requested restriction.
- ✓ Obtain a paper copy of the notice of privacy practices upon request.
- ✓ Inspect and obtain a copy of your health record.
- ✓ Request communications of your health information by alternative means or at alternative locations.
- ✓ Receive an accounting of disclosures made of your health information.

COMPLAINTS

You may complain to Women's Center at Westover Hills and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against filing a complaint.

OBLIGATIONS OF WOMEN'S CENTER AT WESTOVER HILLS

WOMEN'S CENTER AT WESTOVER HILLS IS REQUIRED TO:

- ✓ Maintain the privacy of protected health information.
- ✓ Provide you with this notice of its legal duties and privacy practices with respect to your health information.
- ✓ Abide by the terms of this notice.
- ✓ Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed.
- ✓ Accommodate reasonable request you make to communicate health information by alternative means or at alternative locations
- ✓ Women's Center at Westover Hills reserves the right to change its privacy practice and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you upon your request at your next visit to our practice.

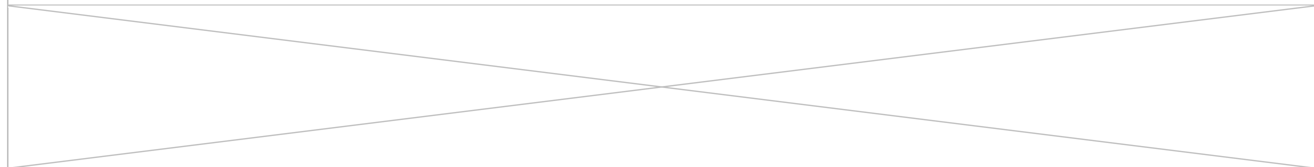
CONTACT INFORMATION

IF YOU HAVE ANY QUESTIONS, COMMENTS, OR CONCERNS, PLEASE CONTACT:

MARTHA M. GONZALEZ
PRACTICE ADMINISTRATOR
1315 N. ELLISON DRIVE
SAN ANTONIO, TEXAS 78251
TELEPHONE: (210) 858-1101

Signature of Patient or Legal Representative (Sign above this line please) Date

Printed Name of Patient or Legal Representative (Sign above this line please) Relationship to Patient



HEALTH MONITORING CONSENT FORM

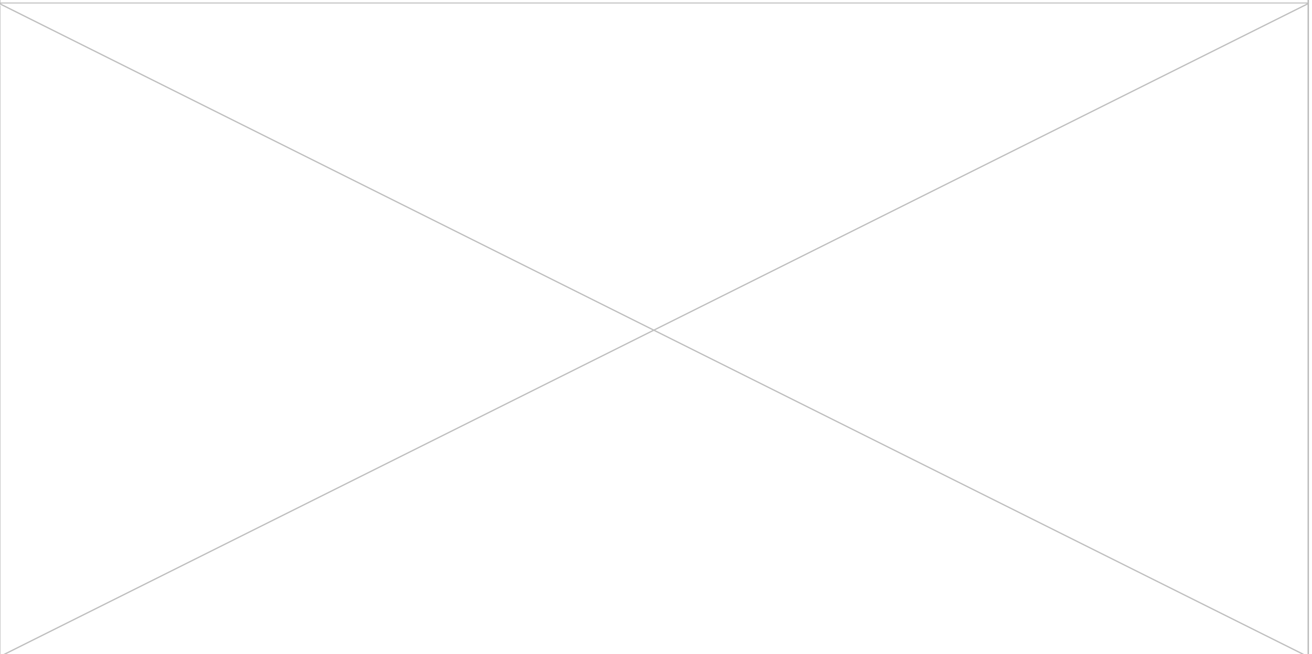
There are many health risks associated with the use of alcohol, prescription and illicit drugs/substances during pregnancy. In order to assist you in obtaining the best possible care during your pregnancy and to provide to you in necessary, with referrals for counseling and treatment, we are requesting that you sign this consent form for alcohol, drug, and substance testing. Your doctor will test you during each trimester of your pregnancy. The following are some of the risks associated with alcohol, illicit and pharmaceutical drugs and or substance use during pregnancy:

Babies born to women who drink alcohol and/or take drugs/substances may be born with mental retardation, have physical and facial abnormalities, growth deficiencies and permanent development problems.

The use of alcohol and/or drugs/substances during pregnancy can slow the growth of the baby causing premature delivery and resulting in low birth weight.

Babies born affected by alcohol and/or drug/substances, need extra medical care and are prone to have more health problems that other children, some of these problems may not show up for years.

With my signature, I consent to test for alcohol, harmful illicit and licit pharmaceutical drugs and substances as it is imperative that my doctor be aware of my current health state to best care for me and my unborn child during my pregnancy. I acknowledge receipt of information regarding the risks involved in using alcohol and/or drugs/substances during my pregnancy. A copy of this consent can be given to me upon request.



Patient's Signature (Sign above this line Please) Date

FINANCIAL POLICY

Thank you for choosing Women's Center at Westover Hills as your health care provider. We are committed to providing you the best available medical care. Our personnel will be happy to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy as well as complete our Patient Registration Form prior to seeing the physician.

Payment for service is due at the time services are rendered. We accept cash, VISA and Master Card. We will be happy to help you process your insurance claim for your reimbursement.

In special instances, we may accept assignment of insurance benefits. However, you must understand that:

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. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. We are however, contracted with certain managed care, and preferred provider plans; we will follow the guidelines for patient care, reimbursement, and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.
2. **All charges are your responsibility whether your insurance company pays or does not pay.** Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will cover.
3. **Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.** If you have an unpaid balance we will reschedule your appointment, unless you make arrangements with our billing department. Co-payments not paid at the time of the service are subject to a $10.00 processing fee.
4. **Pending Medicaid** - Women's Center at Westover Hills **DOES NOT** retroactively bill Medicaid for services performed prior to the date of initial eligibility verification. If you have no other insurance coverage, you will be considered a self-pay patient and will be responsible for all services that you received prior to the initial eligibility date.
5. **OB Patients** - You will be given an estimated payment arrangement based on the amount of you current deductible, and the percentage of co-insurance responsibility set by our contracted rate with your insurance company. Deductibles (not met) are collected in full, along with the co-insurance responsibility. The payments arrangement must be paid in full by your 30th week of pregnancy.
6. **Lab Billing** - Please remember, your lab billing is separate from our physician's billing and you may receive a separate itemized bill from the laboratory, for which you are responsible. Please verify that you are being directed by our office to a lab that is a participating provider with your insurance plan.
7. **FMLA** - The physicians at Women's Center at Westover Hills will provide you with an excuse due to medical illness with specific dates at no charge during a clinic visit. If further information, such as FMLA, Short-Term or Long-Term disability forms are to be filled out there is a $25.00 fee to fill out the paperwork per form. This fee must be paid in full before we submit paperwork.
8. **Returned checks** - The amount of the check plus bank fees will be applied to the amount that the check was written for. If the balances are not collected within 45 days we will issue the check out to the attorney general.

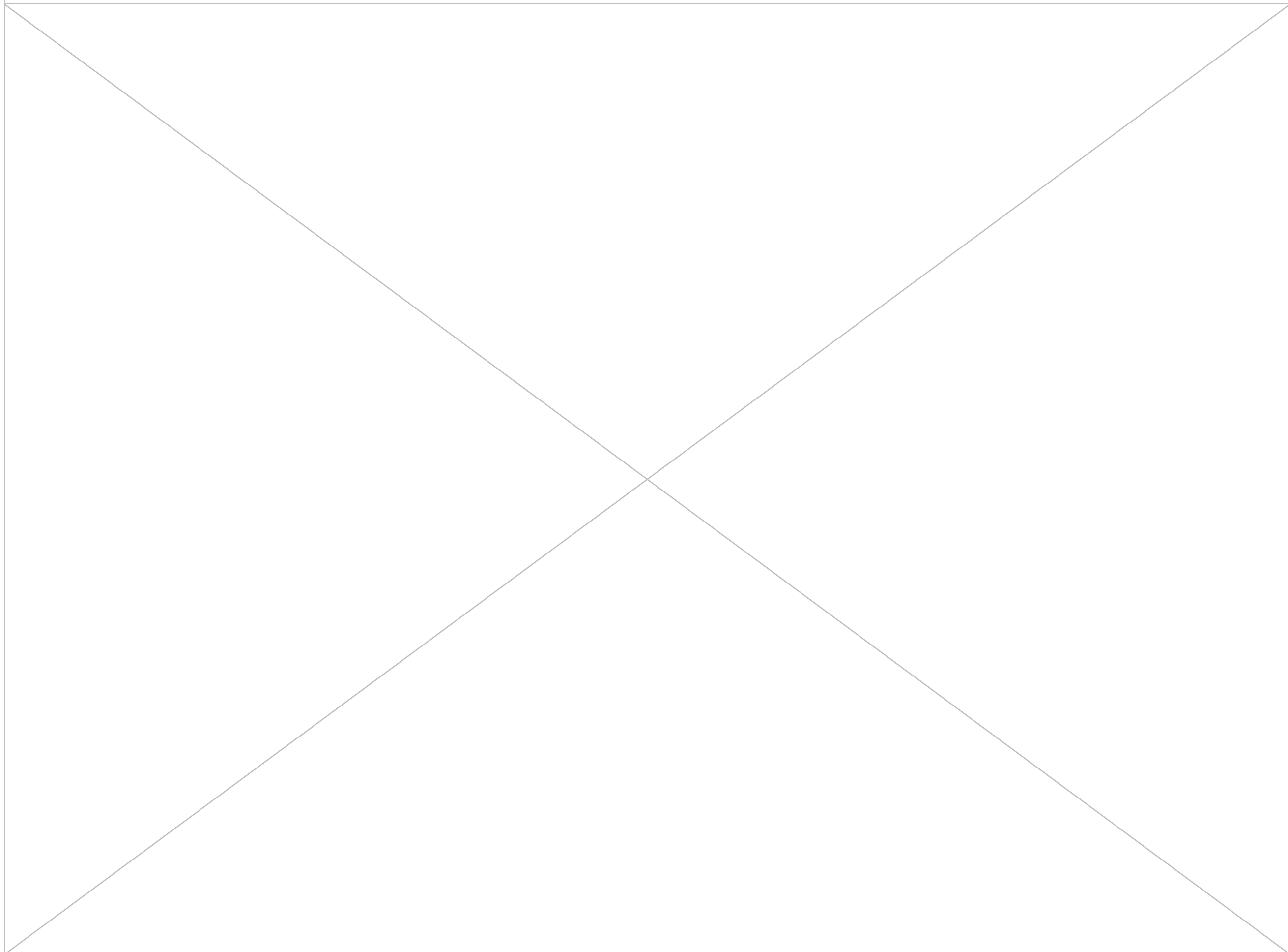
9. **Medical Records** - Dr. to Dr. there is no charge. Patient, Insurance Companies, and 3rd party request will be subject to the following fees: 1st twenty pages $25.00, $0.50 per page thereafter.

10. A charge of $5.00 will be collected when requesting itemized patient account information.

11. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to our patient account specialist, so that we can assist you in your management of your account.

Again, thank you for choosing Women's Center at Westover Hills. We appreciate the opportunity to serve you with individualized care.

Patient's Signature (Sign above this line Please) Date



Health Information Patient Privacy Act (HIPPA)
Notice of Privacy Practices
Acknowledgement and Questionnaire

Please list family member or other persons, if any, whom we may inform about your general medical condition, your diagnosis and any billing questions (including treatment, payment and healthcare operations).

As a reminder these will be the only people we will be able to speak to or release any information to regarding your account.

Name:	**Phone #:**
Name:	**Phone #:**
Name:	**Phone #:**

Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

- ☐ Yes
- ☐ No

Please indicate if we may mail your correspondence if necessary?

- ☐ Yes
- ☐ No

By signing this form, I freely consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

Patient's Signature (Sign above this line Please) Date