Patient Registration Form

QUEEN CITY Women's Health

Name _____ Date _____
First Middle Last

DOB: _____ Age: _____ SSN: _____ Race: _____

Ethnicity: _____ Primary Language: _____ Occupation: _____

Preferred Name: _____ Preferred Pronouns: _____ Gender Identity: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Phone Number: _____ Email: _____

Address: _____ City: _____State: _____ Zip Code: _____

Emergency Contact:_____ Relationship: _____

Emergency Contact Phone Number:_____

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Pharmacy Address: _____

Do you have any cultural or religious beliefs you would like incorporated in your care? ☐ Yes ☐ No

Explain: _____

YOU MUST PRESENT PHOTO ID & INSURANCE CARD AT EVERY VISIT

Primary Insurance

Insurance Company: _____

ID #: _____

Plan: _____

Group: _____

Subscriber: _____

Relationship to Subscriber: _____

Subscriber DOB: _____

Subscriber SSN: _____

Subscriber Employer: _____

Secondary Insurance

Insurance Company: _____

ID #: _____

Plan: _____

Group: _____

Subscriber: _____

Relationship to Subscriber: _____

Subscriber DOB: _____

Subscriber SSN: _____

Subscriber Employer: _____

CONSENT

My signature below indicates that I have given consent to Queen City Women's Health, PC to use and disclose protected health information about me to carry out treatment, payment and healthcare operations that include:

1. Permission to treat and assignment of benefits for services rendered now and in the future.
2. Permission to call my home or other designated location and leave message.
3. Permission to mail items to my home address relating to my personal health and financial information.

I have read, understand and agree to and with the above information.

Patient or Guardian Signature: _____ Date: _____

QCWH Representative Signature: _____ Date: _____

Contact Information & Privacy Form

QUEEN CITY Women's Health

Name: _____ DOB: _____

First Middle Last

Email: _____ Cell Phone Number: _____

Home Phone Number: _____ Work Phone Number: _____

How do you prefer to be contacted? ☐ Home Phone ☐ Cell Phone ☐ Work Phone

May we text you appointment reminders? ☐ Yes ☐ No

May we email you regarding your appointments, results, or referrals? ☐ Yes ☐ No

May we leave a message on your voicemail or answering machine regarding the following information:

Appointment reminders with the office information or provider's name? ☐ Yes ☐ No

Detailed test results? ☐ Yes ☐ No

Referral appointment information? ☐ Yes ☐ No

PERSONAL HEALTH INFORMATION AUTHORIZATION

The HIPAA Privacy Act limits us from releasing information about you without your consent. These limitations include appointment and billing information along with your medical information. In some cases you may want to authorize someone, such as your spouse, to have access to your information with or without restriction.

Please list any person(s) that you authorize to have access to your information:

1. Name: _____ Relationship: _____

   DOB: _____ Phone #: _____

   Restrictions? ☐ Yes ☐ No Explain: _____

2. Name: _____ Relationship: _____

   DOB: _____ Phone #: _____

   Restrictions? ☐ Yes ☐ No Explain: _____

3. Name: _____ Relationship: _____

   DOB: _____ Phone #: _____

   Restrictions? ☐ Yes ☐ No Explain: _____

PRIVACY PRACTICE POLICY

I have received a copy of Queen City Women's Health, PC Privacy Policy Practices. My signature below indicates that I have received, read, and understand the Privacy Practice Policy.

I have read, understand and agree to and with the above information.

Patient or Guardian Signature: _____ Date: _____

QCWH Representative Signature: _____ Date: _____

Queen City Women's Health Notice of Office Policies

Thank you for entrusting your care to us. This notice has been created to cover several informative items about our office that we believe enables us to take the best care of you.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all services rendered to me by Queen City Women's Health,PC and that payment is due at the time of service unless prior arrangements have been made and agreed upon. I am aware that Queen City Women's Health, PC will file my insurance as a courtesy to me and agree that I am liable for co-pays, deductibles and any other balances not paid by my insurance. I further understand and agree that my failure to pay any outstanding balances will result in referral of my account to an outside source and I will be responsible for all fees incurred up to and including interest, legal fees and court costs.

I have read, understand and agree to and with the above information. _____ **Patient Initials**

CHILD POLICY

No children under the age of 13 are allowed in the office or waiting room, with the exception of newborns up to 8 weeks of age. This is not intended to be an inconvenience for our patients with children, it is for the protection of our pregnant mothers and unborn children. We will require patients to reschedule when children are brought to their scheduled appointments. In extreme circumstances, the provider has discretion to make a case by case assessment to allow children.

I have read, understand and agree to and with the above information. _____ **Patient Initials**

VISITOR POLICY

Only one person may be with you during your office visit and ultrasounds. In special circumstances an exception may be made at the discretion of the provider with prior approval.

I have read, understand and agree to and with the above information. _____ **Patient Initials**

LATE POLICY

There is a 10 minute grace period. If you are more than 10 minutes late for your appointment, you will be rescheduled. If there is an emergency or extenuating circumstance, please notify the office prior to your scheduled appointment time.

I have read, understand and agree to and with the above information. _____ **Patient Initials**

NO SHOW POLICY

We ask that you give at least 24 hour notice when you are unable to make your appointment. If you do not cancel prior to the appointment time, you will be charged a NO SHOW fee. The NO SHOW fee must be paid prior to making any future appointments. After 3 "NO SHOW appointments" you will be discharged from the practice. Obstetric patients will be addressed on an individual basis but may be subject to discharge from the practice.

NO SHOW Fees are as follows:

- Office Visit $50 (if not canceled within 24 hours)
- In Office Procedure $100 (if not canceled within 1 week)
- Surgery $200 (if not canceled within 1 week)

I have read, understand and agree to and with the above information. _____ **Patient Initials**

INSURANCE

We accept most insurance plans. As a courtesy, we file the insurance claims for you. If at anytime your insurance changes, it is your responsibility to make our office aware.

<u>WE ARE NOT ACCEPTING ANY NEW BLUECARE PATIENTS AT THIS TIME. AS TENNOVA HEALTHCARE CLARKSVILLE DOES NOT ACCEPT THIS INSURANCE.</u>

I have read, understand and agree to and with the above information. _____ **Patient Initials**

PHOTO ID & INSURANCE CARD

We request that you present your ID and insurance card at every visit or you may be subject to rescheduling your appointment. This is to ensure proper patient identification and insurance verification.

I have read, understand and agree to and with the above information. _____ **Patient Initials**

Queen City Women's Health Notice of Office Policies Continued

FMLA or SHORT TERM DISABILITY PAPERWORK

Any paperwork to be completed by our office requires a 2 week turnaround time. Paperwork for the patient is free, for a spouse or other family member, the cost is $25. If the paperwork needs to be expedited, there will be an additional $50 fee that must be paid when the paperwork is submitted to us.

LABS

All specimens we collect in our office will go to PathGroup. There is a PathGroup draw station available in our office for your convenience. In office lab hours are as following, but are subject to change.

- Monday, Tuesday, Thursday, Friday
    - 8:30am - 11:45am (last 1hr Glucose Test @ 10:45am)
    - 1:30pm - 4:45pm (last 1hr Glucose Test @ 3:45pm)
- Wednesday
    - 8:30am - 1:00pm (last 1hr Glucose Test @ 12:00pm)

PathGroup also has a satellite location available for your use or for specific tests (such as 3hr Glucose Tolerance Tests). Lab location information: PSC Clarksville 201 Uffelman Drive, Suite A Clarksville, TN 37043
Hours: Monday – Friday 8:00 am – 5:00 pm

OB CONFERENCES

It is a requirement that you attend the OB Conference. These conferences are done every Thursday and Friday from 8am-9am in a group setting with individual financial consult to follow. In special circumstances alternative arrangements can be made on an individual basis subject to the discretion of the QCWH representative.

MATERNITY BENEFITS

Please contact your insurance to ensure you have maternity benefits with your insurance plan. If you do not have maternity benefits, you may follow our self-pay payment plan.

CESAREAN SECTIONS AND VBACS

Our providers follow ACOG guidelines for VBAC deliveries. You and your provider will discuss and decide this together.

DELIVERY/BIRTH

All deliveries will be at Tennova Healthcare Clarksville, 651 Dunlop Ln Clarksville, TN 37040. Our doctors and nurse midwives rotate call. In the event you of delivery outside of a scheduled C-Section or Induction, the on-call provider will care for you and deliver your baby. We will always have someone from our team available to deliver your baby, though it may not be your specific provider.

POSTPARTUM CARE

If you have a C-Section or complications, you will be provided information on follow up at the hospital when you are discharged. The nurse will address any questions or concerns you may have at that time.

You will follow up for a 6 week postpartum exam where you will be screened for postpartum depression and have a physical exam to ensure you have healed well. The providers will address any questions or concerns you may have and discuss birth control options.

I have read, understand and agree to and with the above information.

Patient or Guardian Signature: _____ Date: _____

QCWH Representative Signature: _____ Date: _____

Queen City Women's Health Notice of Privacy Practices

Effective July 5, 2022

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

We understand that medical information about you and your health is personal. Queen City Women's Health and its employees are required by law to maintain the privacy of your health information, follow the terms of this notice, and provide you with a copy of this notice of our legal and privacy practices in regards to your health information.

How we may use or disclose your health information:

Queen City Women's Health protects your health information. In certain circumstances, we must have your written authorization to use or disclose your health information. However, we are permitted by law to use or disclose your health information as listed below without your authorization.

FOR TREATMENT – Information obtained by us will be used to render medical care to you. Health Information about you may be disclosed to other health care providers and persons involved in your medical care.

FOR PAYMENT - We may use and disclose your health information so that your medical services may be billed to and payment collected from you, an insurance company or a third party administrator.

FOR HEATLH CARE OPERATIONS – We may use or disclose health information about you for our business operations. Unless you provide us with specific instructions, we may send materials related to your health care to your home through the mail or via telephone communications. These types of uses and disclosures are necessary to operate this business and provide you with the highest quality of care and service.

AS REQUIRED BY LAW – We will disclose information about you when required to do so by federal state or local laws.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY – We may use or disclose health information about you when necessary to prevent serious threat to your health and safety or the health and safety of another person or the public in general. This type of disclosure would be limited to someone able to help prevent the threat.

PUBLIC HEALTH RISKS – We may disclose health information about you for public health activities. These activities generally include the following: (a) to prevent or control disease, injury or disability; (b) to report adverse effects or problems with products; (c) recall notifications; (d) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; (e) to notify the appropriate government authority if we believe a person has been the victim of abuse neglect or domestic violence (we will only make this disclosure if you agree and when required or authorized by law).

FOR HEALTH OVERSIGHT ACTIVITIES - We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include audits, investigations, inspections and licensure.

LAWSUITS AND DISPUTES – If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court order or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

FOR SPECIFIC GOVERNMENT FUNCTIONS - We will disclose health information on you for the following specific government functions: (a) health information of military personnel, as required by military command authorities; (b) health information of inmates to a correctional institution or law enforcement official; (c) in response to a request from law enforcement if certain conditions are met; and (d) for national security reasons.

When we may NOT use or disclose your health information:

Except as described in this notice, Queen City Women's Health will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your rights regarding your health information:

You have the right to request restrictions on certain uses and disclosures of your health information. Queen City Women's Health is not required to agree to a restriction that you request. Should we agree to your request, we will put the agreement in writing and follow it except in emergency situations. We cannot agree to limit the uses of disclosures of information that is required by law.

You have the right to inspect and copy your health information as long as it is maintained by Queen City Women's Health. Your health information will include all clinical data collected on and about you from your first encounter in this practice. To inspect or copy your health information you must submit a written request. We may charge a fee for the costs necessary to grant your request. Your request may be denied in limited circumstances. In the case of a denial, you may ask for a review.

You have the right to choose a summary as opposed to a copy of your health information. You have the right to request that Queen City Women's Health amend your health information that is incorrect or incomplete. To request any amendment, you must submit a written request along with explanation of the request. Queen City Women's Health is not required to amend health information that is accurate and complete.

You have the right to request on accounting of disclosures of your health information made after the effective date of this notice. The accounting of disclosures excludes disclosures for (a) treatment, payment and health care operations; (b) to you or based upon your authorization and (c) certain government functions. To receive an accounting you must submit a written request specifying the time period, which may not be longer than seven years.

You may request communications of your health information by alternative means or at alternative locations. For example you may request that we contact you about health matters only in writing or at a different address. You must submit a written request stating exactly how you want to be contacted. Queen City Women's Health will accommodate all reasonable requests.

If you wish to exercise any of these rights, submit a written request to Queen City Women's Health ATTN: Office Manager, 751 Chesapeake Ln, Suite 101, Clarksville, TN 37040. All requests will be responded to within 30 days of the date received.