CAPITAL WOMEN'S CARE, LLC.

Please update the information below, sign the form, and return the form to the front desk. Thank you.

Patient Information

Today's Date:	Account	Referring Physician:	Appt Info:	
Name:	Marital Status:	Gender:	Date of Birth:	Social Security #:
Address:	APT #:	City,State, Zip:		
HOME MSG YES	CELLULAR MSG YES	Ext:		

GUARANTOR/FINANCIALLY RESPONSIBLE PARTY

Guarantor Name:	Date of Birth:	Social Security #:	Phone 1:
Address:	City, State, Zip:		Phone 2:
Employer:	Employer Address:		Occupation:

PRIMARY INSURANCE INFORMATION

Have you applied or intend to apply for Medical Assistance? ◯ Yes ◯ No ◯ Not sure

Insurance Company:	ID #:	Group #:
Address:	City, State, Zip:	Phone:
Policy Holder's Name:	Policy Holder's Date of Birth:	Policy Holder'sSocial Security #:
Policy Holder's Employer:	Patient's Relation to Policy Holder:	Insurance Effective Date:

SECONDARY INSURANCE INFORMATION

Please note, insurance companies require you to notify them if you have other insurance. If they do not have this information in their system, they will not pay the claim for this visit.

Insurance Company:	ID #:	Group #:
Address:	City, State, Zip:	Phone:
Policy Holder's Name:	Policy Holder's Date of Birth:	Policy Holder's Social Security #:
Policy Holder's Employer:	Patient's Relation to Policy Holder:	Insurance Effective Date:

PERSONAL REPRESENTATIVE AUTHORIZED TO ACCESS PROTECTED HEALTH INFORMATION

Name:	Phone#:	Name2:	Phone#:

1. Financial Responsibility:

I certify that the information I have provided regarding my insurance coverage is correct and I authorize Capital Women's Care to verify insurance coverage and benefits allowed in accordence with my insurance plan's coverage.

I authorize that payments be made directly to Capital Women's Care for all medical insurance benefits which are payable under the terms of my insurance policy for services provided. I agree to pay any copayment, coinsurance, or deductible as required by my insurance for medical care provided to me or my dependant. I understand that I am responsible for knowing the terms and regulations of my insurance plan.

Capital Women's Care may impose a no-show fee of $35.00 for appointments not cancelled 24-hours in advance. Capital Women's Care may impose reasonable interest, late charges, direct collection costs(25%) and or reasonable attorney's fees should my account become delinquent. There will be a $40.00 fee assessed for all returned checks.

2. Payment in full at time of service:

I understand that if Capital Women's Care does not participate with my insurance or I do not have insurance, payment is due in full at the time of service

3. Release of Medical Information for Billing:

I hereby authorize Capital Women's Care to submit a claim and a copy of medical records related to such services, to my insurance company, health and welfare fund, Medicare or Medicaid for medical services provided to me or my dependant. I also authorize Capital Women's Care to provide a copy of this release and a copy of medical records related to such services if requested by the payor. Further, I authorize Capital Women's Care to release medical information to my consulting or primary physician to assit with continuity of care. This release will expire one year from the date of my signature below, unless I cancel this release in writing prior to that date.

4. Receipt of Privacy Notice:

I have been given the opportunity to review the Capital Women's Care Notice of Privacy Practices which provides a detailed description of how my Protected Health Information (PHI) is used and disclosed.

5. Non-Covered Services:

I agree to pay for medical services provided to me or my dependant which are not covered by the benefits in my insurance plan.

I AGREE TO THE ABOVE STATED CONSENT

Signature of Patient or Legal Guardian: **Date:**

CAPITAL WOMEN'S CARE, LLC.

Please update the information below, sign the form, and return the form to the front desk. Thank you.

Patient Information

Name: Account Number: Today's Date:

How did you learn about our practice? ☐ Patient Referral ☐ Other Referral ☐ Website / Internet
☐ Advertising / Radio / TV ☐ Other: _____

Patient Race and Ethnicity (please circle your responses)

Ethnicity: Hispanic/Latino OR Not Hispanic/Latino

Race: Asian, Black or African American, White, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander

Patient Allergies (please include your reaction to each allergy)

Allergen	Reaction

Patient Medications (please include the dosage for each medication)

Medications	Dosage

Patient Preferred Pharmacy

Pharmacy Name:

Street Address:

City, State Zipcode:

Pharmacy Phone#:

Email Communications

Capital Women's Care physicians are dedicated to helping our patient's live healthy lifestyles. Your physician would like the opportunity to send patients reminders about preventative health services - such as well women exams - or other information that may assist our patients in living a healthy lifestyle. Also, there may be other messages we would like to send our patients, such as the announcement of new physicians or contract changes with insurance companies.

Capital Women's Care makes this commitment to our patients about the collection of e-mail information.

1. They will be for Capital Women's Care use only. They will not be given or sold to any other entity.
2. The patient's privacy will be protected. The e-mail address will not be used to communicate any personal health information or in any manner inconsistent with the Health Insurance Portability and Accountability Act (HIPAA).

Our e-mailing to our patients will be one way communications and, therefore, will not allow for conversations between the patient and physician/staff. All Health related questions should continue to be addressed to the appropriate Capital Women's Care staff. Additional comments and questions should be directed to the Capital Women's Care Compliance Officer at privacy@cwcare.net<mailto:privacy@cwcare.net> or (301) 340-8339, ext. 201.

Patient Name: (printed) _____

E-Mail Address: _____

Patient Signature: _____

Date: _____

Capital Women's Care, LLC
Capital Women's Care Specialty Center, LLC
ENK SurgiCenter, LLC

Use and Disclosure of Protected Health Information

Section I: PATIENT ACKNOWLEDGEMENT & CONSENT FORM

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Capital Women's Care, LLC, Capital Women's Care Specialty Center, LLC and ENK Surgery Center, LLC may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices states that we reserve the right to change terms described. Should this happen we will display the new policy and effective date at each of our Capital Women's Care Locations.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you.

*By signing below, you acknowledge receipt of our **Notice of Privacy Practices**.*

Patient's Signature _____ Date _____

Print Full Name _____

Section II: CONSENT FOR USE AND DISCLOSURE OF INFORMATION

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Capital Women's Care, LLC for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits for related services. I agree to provide all reference and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Patient's Signature _____ Date _____

Print Full Name _____

- OVER -

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPAA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Section III (Optional):
PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED

Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

Name of Authorized Person or Entity	Relationship	Phone #
Name of Authorized Person or Entity	Relationship	Phone #

Section IV: AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL

Capital Women's Care physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, work, or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

_____ (Initial) Yes, I agree to allow Capital Women's Care physicians and healthcare staff to leave messages that include Protected Healthcare Information on all three communication devices: home, work and cell phone.

_____ (Initial) I agree to allow Capital Women's Care physicians and healthcare staff to leave messages that include Protected Healthcare Information on the following: Please initial next to the applicable communication devices: _____ home number, _____ work number or _____cell number.

_____ (Initial) No, I do not agree to allow Capital Women's Care physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

_____
Patient's Signature Date

For CWC Internal Use Only

Section V: UNABLE TO OBTAIN NOTICE RECEIPT ACKNOWLEDGEMENT

Option 1: I could not obtain a signed Notice Receipt Acknowledgement from the patient for the following reason:

_____

_____

Option 2: I attempted to obtain a signed Notice Receipt Acknowledgement from the patient on ____/___/___, but was unable for the following reason:

_____

_____

_____

_____
CWC Employee Signature Date

CAPITAL WOMEN'S CARE
GENETIC COUNSELING/TERATOLOGY COUNSELING

Patient Name: _____ Date: _____

Father of Baby Name_____ Phone Number_____

1. Patient's age 36 years or older as of estimated date of delivery	Yes	No
2. Thalassemia (Italian. Greek, Mediterranean or Asian background)	Yes	No
3. Neural Tube Defects (meningomyelocele, spina bifida or anencephaly)	Yes	No
4. Congenital heart defect	Yes	No
5. Down Syndrome	Yes	No
6. Tay Sachs (Ashkenazi Jewish, Cajun, French Canadian)	Yes	No
7. Canavan Disease (Ashkenazi Jewish)	Yes	No
8. Familial dysautonomia (Ashkenazi Jewish)	Yes	No
9. Sickle Cell disease or trait (African)	Yes	No
10. Hemophilia or other blood disorders	Yes	No
11. Muscular dystrophy	Yes	No
12. Cystic fibrosis	Yes	No
13. Huntington's chorea	Yes	No
14. Mental Retardation/autism	Yes	No
15. Other inherited genetic or chromosomal disorder	Yes	No
16. Maternal metabolic disorder (e.g.: Type 1 Diabetes, PKU)	Yes	No
17. Patient or baby's father had a child with birth defects not listed above	Yes	No
18. Recurrent pregnancy loss or a stillbirth	Yes	No
19. Medications (including supplements, vitamins, herbs, or OTC drugs/		
Illicit/rec. drugs/alcohol since LMP	Yes	No

If yes, agent and strength/dosage:

_____
_____
_____