



PETERSON

Women's Associates

575 Hill Country Drive
 Suite 202
 Kerrville, Texas 78028
 Phone: 830.258.6237 | Fax: 830.315.1366

Patient Name (last, first, MI)			Date of Birth	Social Security Number	
Mailing Address			Home Telephone		Work Telephone
City	State	Zip Code	Cell Phone		Marital Status
Primary Care Physician			Driver's License Number		
Patient's Employer			Email Address		
Patient's Race			Patient's Ethnicity		
Emergency Contact: Name & Number			Relationship of Contact to You:		
Spouse's Name			Work Telephone		
Spouse's Employer					
Spouse's SS#			Spouse's Date of Birth		
INSURANCE INFORMATION					
Medicare Number			Medicaid Number		
Primary Health Plan			Secondary Health Plan		
Group#		ID#	Group#		ID#
Name of Policy Holder (last, first, MI)			Name of Policy Holder (last, first, MI)		
Policy Holder Address			Policy Holder Address		
Telephone Number		Date of Birth	Telephone Number		Date of Birth
Social Security#			Social Security#		
Preferred Pharmacy:					
_____ Signature of Patient or Responsible Party				_____ Date	



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PATIENT AUTHORIZATION FOR CONTACT & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

This information allows us to release you medical information to only the people listed below. Your doctors are always informed, so you do not need to list them.

I authorize Peterson Women's Associates to disclose my protected health information to:

_____ Ph #: _____ Relationship: _____
_____ Ph #: _____ Relationship: _____
_____ Ph #: _____ Relationship: _____

_____ Myself Only (You will be the only person that will receive or obtain information from our office.)

I authorize Peterson Women's Associates to disclose only the following information to the individual(s) listed above:

_____ Test results, reports, and general health updates
_____ Nothing beyond general health questions and updates
_____ Appointment information (date& time)

I authorize Peterson Women's Associates to contact me regarding health information by:

_____ E-mail: _____
_____ Please send detailed email
_____ Please send only call back information
_____ Phone: _____ Home / Cell / Work (please specify)
_____ Please leave detailed message on voicemail or answering machine
_____ Please leave information with any of individual(s) listed above
_____ Please leave a message with only call back information

This authorization will remain in effect until terminated by patient, patient's representative, or other individual of legal entity authorized to do so by court order or law by submitting request in writing to our office. You will be asked to update this form each year.

Patient Signature

Date



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PRACTICE POLICIES AND GUIDELINES AGREEMENT

Welcome! We are so glad that you have decided to become a part of our practice. Our goal is to provide you with excellent healthcare in a friendly and compassionate environment. Please take a moment to become familiar with our office's policies and guidelines.

First Time Visit: Please arrive at least 20-30 minutes prior to your appointment time. A nurse will go over your medical history. Please bring a list of your medications. If you have a copay or have not met your deductible, please be prepared to pay it when you check in at the front desk. If you are a self pay patient, payment will be collected after you have seen the provider. Payment is due at the time of service.

Follow up Visits: Please arrive on time for your appointment. It is our goal to see you at your scheduled appointment time and would like for you to be ready to be seen at that time as well.

Late Arrivals: We all run late sometimes. In the event you are late for your appointment, we will try our best to work you back in to the schedule. Depending on how busy we are, you may be required to reschedule your appointment.

Appointment Cancellations: We understand that sometimes plans change. We ask that you reschedule appointments at least 24 hours in advance so that we may give that time to someone else. Although unexpected events may necessitate missing an appointment, if you miss 2 appointments without following the cancellation protocol you will be charged a \$25.00 fee and will receive a warning notification. If you miss 3 appointments you are at risk of being dismissed from the practice. In the event you are dismissed you will receive notice in writing sent via certified mail.

Problem Visits: Established patients who need acute care should call as early in the day as possible so that we are able to accommodate you. Patients are seen by appointment only. Depending on the availability of your provider, you may be asked to see another provider.

Medication Refills: For non-emergency and routine medication refills, please allow 48 hours for response. Please ask your pharmacy to send us a refill request. Also, please let us know if you need a 90 day supply. Narcotic medications will only be written for a 30 day supply. Additional refills to the original prescription will be at the provider's discretion. Early refills will not be given. You may be asked for a follow up appointment for certain refill requests.

I have read and understand the above office policies and agree to abide by them.

Signature

Date



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PATIENT NOTICE OF BILLING PRACTICES

Peterson Women's Associates is committed to providing quality medical services to our patients and clearly defining our financial policy. If you have any questions please ask one of our staff members to assist you.

Payment Due At Time of Service: Medical services provided to you are payable at the time of service. We accept cash, check, debit cards and most major credit cards.

_____ (initial) I understand that I am responsible for payment of co-pays, deductibles and co-insurance at the time service is provided.

_____ (initial) I understand past due amounts must be paid in full prior to the scheduling of any future appointments, unless prior arrangements have been made and approved by management.

Self Pay Patients: Payment is due in full at the time of service. We offer a private pay discount of 20%.

Insurance Billing: Our office bills most major insurances. Any services provided that are not covered by your insurance will become your responsibility. Any services provided that are applied towards your deductible will also become your responsibility. You will receive a statement by mail for these charges. Should you have any questions regarding a statement you received please contact our billing office.

Medicaid Billing: We currently accept the following Medicaid plans: Traditional Medicaid, Women's Health Plan, Molina Health Care, Superior CHIP Perinate and Superior. Your Medicaid must be active at the time of service. We do not accept Retro-Medicaid, or back bill for any services provided prior to you becoming eligible for Medicaid.

Medicare Billing: We currently accept Medicare patients. Medicare deductibles and co-insurance are due in full at the time of service. Any services provided that are not covered by Medicare will become patient responsibility and you will receive a statement by mail.

Patient Credits: Patient credits will be refunded once all visits have been responded to by insurance. No refunds will be issued while there are future appointments scheduled.

Collections: Our preference is to ALWAYS work with our patients directly. If you are having difficulty paying your bill, please call our billing department. Any balances that remain unpaid after 90 days may be forwarded to our collection agency. If your account is forwarded to collection, you will assess additional fees.

I have read the above payment notice and understand my financial responsibility. If I have additional questions I understand that I may speak with one of the office staff members or a billing representative.

Patient Printed Name

DOB

Patient Signature

Date



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Acknowledgement of Receipt of Notice of Privacy Practice

I understand that as a part of the provision of health services, Peterson Women's Associates creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnosis, treatment and any plans for future care or treatment.

I have received a paper copy of Peterson Women's Associates Notice of Privacy Practices (HIPPA), which explains how my medical information will be used and disclosed.

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

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that the Practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health information which have been previously agreed upon.

Patient name

____/____/____
DOB

Signature

____/____/____
Date

Our patient was handed a copy of our Notice of Privacy Practices (HIPPA) and a good faith effort to obtain written acknowledgement was made. This effort was declined by the patient.

Employee signature

____/____/____
Date