

## **New Patient Registration Form**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

### **Emergency Contact**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

### **Preferred Pharmacy**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

### **Alternate Pharmacy (if applicable)**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Primary Care Doctor \_\_\_\_\_

Office Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**PHILADELPHIA WOMEN'S HEALTH & WELLNESS**  
**CONSENT TO LEAVE MESSAGES /SHARE INFORMATION WITH FAMILY & FRIENDS**

I understand that my healthcare information is protected. I understand that, in order for us to leave detailed messages containing specific dental information on my voicemail or answering machine, I need to give permission for us to do so.

**Consent for Leaving Messages**

I give my permission for messages to be left on my phone number(s) below:

( ) Cell # \_\_\_\_\_ ( ) Home # \_\_\_\_\_ ( ) Work # \_\_\_\_\_

( ) I prefer not to have voice mail messages from the office

Regarding the following:

( ) Appointment Reminders/Changes ( ) Account Payments/Balances ( ) Cost Estimates

( ) Needed Treatment/Completed Treatment

**Consent for Shared Information with Family & Friends**

**Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.**

The name(s) listed below are family members or friends to whom I grant permission for PWH&W and their representatives at our office to verbally discuss my care using their best judgment and grant them permission to disclose <sup>medical</sup> information that is relevant to my care or relevant for payment.      **Yes      No**

	NAME	RELATIONSHIP	PHONE NUMBER
1			
2			

Regarding the following:

( ) Appointment Reminders/Changes ( ) Account Payments/Balances ( ) Cost Estimates

( ) Needed Treatment/Completed Treatment

**It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.**

\_\_\_\_\_  
Printed Name (Patient/Parent)

\_\_\_\_\_  
Signature (Patient/Parent)      Date

# **PATIENTS RIGHTS AND RESPONSIBILITIES**

## **CONFIDENTIALITY**

It is the policy of **Philadelphia Women's Health & Wellness** to treat all patient information confidentially. This includes patient records and conversations. We will investigate any reported violation of this policy. If you have any questions, please ask a front desk representative for information. **Philadelphia Women's Health & Wellness** makes every effort to provide our patients with an environment, which is safe, private and respectful of our patient's needs. If you have a complaint about our services, facilities or staff, we want to hear from you. We will do everything we can to see that your experience with us is professional in every way.

## **ISSUES OF CARE**

**Philadelphia Women's Health & Wellness** is committed to your participation in care decisions. As a client, you have the right to ask questions and receive answers regarding the course of clinical care recommended by any of our health providers, including discontinuing care. We urge you to follow the healthcare directions given to you by our providers. However, if you have any doubts or concerns, or if you question the care prescribed by our providers, please ask.

## **PATIENT RIGHTS**

1. The patient has the right to receive information from health providers and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their health providers as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their health providers might have, and to receive independent professional opinions.
2. The patient has the right to make decisions regarding the health care that is recommended by his or her health provider. Accordingly, patients may accept or refuse any recommended medical treatment.
3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs, regardless of race, religion, ethnic or national origin, gender, age, sexual orientation, or disability.
4. The patient has the right to confidentiality. The health provider should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.
5. The patient has the right to continuity of health care. The health provider has an obligation to cooperate in the coordination of medically indicated care with other health providers treating the patient. The health provider may discontinue care provided they give the patient reasonable assistance and direction, and sufficient opportunity to make alternative arrangements.

## PATIENT RESPONSIBILITIES

1. Good communication is essential to a successful health provider-patient relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their health providers.
2. Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to present health.
3. Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.
4. Once patients and health providers agree upon the goals of therapy, patients have a responsibility to cooperate with the treatment plan. Compliance with health provider instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed-upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.
5. Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk.

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Patient Name

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Date

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Date of Birth

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Chart Number

# PATIENT RESPONSIBILITY FORM

## 1. Individual's Financial Responsibility

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to the visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the cost of all services provided.
- If I am uninsured, I agree to pay for medical services rendered to me at the time of service.

## 2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

- I hereby authorize and direct payment of my medical benefits to Philadelphia Women's Health & Wellness on my behalf for any services furnished to me by the providers.

## 3. AUTHORIZATION TO RELEASE RECORDS

- I hereby authorize Philadelphia Women's Health & Wellness to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to another medical provider.

## 4. MEDICARE REQUEST FOR PAYMENT

- I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Philadelphia Women's Health & Wellness. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

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Signature of Patient, Authorized Representative or Responsible Party

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Date

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Print Name Patient, Authorized Representative or Responsible Party

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Relationship to Patient

## Acknowledgement of Notice of Privacy Practices (NPP)

A Notice of Privacy Practices (NPP) is provided to all patients. The Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

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Name of Patient

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date Signed

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Signature of Patient

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Name of Patient's Personal Representative

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date Signed

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Signature of Patient's Personal Representative

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FOR INTERNAL USE ONLY

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Name of Employee

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Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained

- Patient was unable to sign.
- Patient refused to sign
- Other \_\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_ (Date: As noted on NPP)