Patient Information

First Name (Legal Name) **Last Name** **Middle Initial**
Preferred Name

Home Address **City** **State** **Zip Code**

Date of Birth **Primary Number** ☐ Home ☐ Cell **Secondary Number** ☐ Home ☐ Cell

Social Security Number **Relationship Status** :

_____-_____-_____ S M W D Sep

Email Address (used for appointment reminders and newsletter)

_____@_____.com

Insurance Policy Holder's Name, *if not patient: -*

_____

May we contact you via ☐ Text Message ☐ Email ☐ Voice

Patient Employer _____ **Employment Status** FT PT Self Retired

Patient Work Phone _____ Student Other_____

Emergency Contact Name:_____**Number**_____**Relationship**_____

Minnesota State/Federal Government REQUIRES we ask the following questions

Primary Language (circle one)
English Spanish Somali
Other_____

Race (circle one or more)
Caucasian Hispanic Asian
Chinese African American Other_____

Ethnicity (circle one)
Hispanic or Latino
Not Hispanic or Latino

Religion_____

Country of Origin: _____

Primary Care Doctor

Primary Care Doctor/Clinic? _____
Phone:_____Address/Location:_____

Referral Information

How did you hear about us? _____

Discloser of Information Permission Form

I hereby grant permission for the Comprehensive Healthcare for Women, P.A. doctors, staff or designees to discuss my care or any information in medical chart including billing statements with the following person(s). I understand that this written notification is effective immediately and indefinitely and can only be revoked or changed by myself in writing. This is in accordance with HIPPA regulations.

Name of Person:_____**Relationship**_____

PLEASE COMPLETE PAGE 2

Release of Information

My insurer may share my past, current and future health and account records with Comprehensive Healthcare for Women about services I've received from Comprehensive Healthcare for Women and other care providers unrelated to Comprehensive Healthcare for Women. These records may be used by Comprehensive Healthcare for Women as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

_____My insurer may **not** release any of my identifiable health records from providers unrelated to Comprehensive Healthcare for Women for the purposes described above.

Patient Signature _____ **Date** _____

Signature on File, Assignment of Benefits, Financial Agreement, HIPAA Compliancy

I hereby authorize Comprehensive Healthcare for Women, P.A., or its designees, permission of treatment. I further authorize release of information necessary to file and adjudicate claims with my insurance company and assign benefits, otherwise payable, to Comprehensive Healthcare for Women, P.A. I agree that I am responsible for paying Comprehensive Healthcare for Women, P.A. and any balances due including co-pays, deductibles and non-covered services, which remain after insurance payments have been made. If full payment cannot be made, I agree to make payment arrangements with Comprehensive Healthcare for Women, P.A representative. By signing this form, I am acknowledging that I have received and/or have access to the Notice of Privacy Policy Practices from/of Comprehensive Healthcare for Women, P.A. I'm also aware I could be charged the following fees:

- $25 fee for all checks returned unpaid by bank
- Additional 16% fee, of my outstanding balance, if my account is forward on to an outside collection agency.

Patient Signature _____ **Date** _____

Patient Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, herby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practice* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.
I also understand that if I have any questions or complaints, I may contact:

Heather Manship, Office Manager, 651-209-8125 or heather@chcw.net

You may also contact the Secretary of the U.S Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S Department of Health and Human Services.
Patient or Personal Representative

Signature: _____ Date: _____/_____/_____

Name(if not the patient): _____

Relationship to Patient: _____

For Office Use Only:
We made a good-faith effort to obtain an acknowledgement of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons:

- ☐ Patient refused to sign (date of refusal) _____/_____/_____
- ☐ Communication barriers prohibited obtaining an acknowledgment
- ☐ An emergency situation prevented us from obtaining an acknowledgment.
- ☐ Other: _____

Attempt made by (CHCW staff): _____ Date: _____

(revised 2/5/2015)