Genis Women's Care, PC
2790 Godwin Blvd. # 375
Suffolk,Va. 23434

Patient Registration Form

****
Name____DOB: ___/___/_____Race: _____________

Address: ______________________________________City: ____________________State: _________

Zip: ___________Home Phone: (_____)______-_______ SSN: __________________________________

Marital Status: __________Employer: _____________________________Work # __________________

Primary Care Physician: __________________________Phone:(_____)_____-________________

E-mail: ______________________

****
Policy Holder/Guarantor Name: ___________________________________DOB:____/____/____________

SSN: _____-____-_______Insurance Name: ____

Policy/ID #__________________________________Group #: __________________________________

Effective Date: _____/___/______ Any other Insurance: please circle Y/N

****

Emergency Contact:____Relationship: __________________

Phone:(_____)_____-________ Address: ____

City: _________________________________State: ____

****

I hereby authorize treatment for the above mentioned patient and certify that the information is correct. I permit a copy of this authorization to be used in place of the original. I authorize the release of medical information to any company insuring said patient and assigned benefits from any Insurance coverage to : Genis Women's Care, PC.

The undersigned patient and/or guarantor agrees to be responsible for all charges for professional services rendered by Genis Women's Care,PC. If payment for these services are not made when agreed upon, I agree to pay, in addition to the physician fee, all cost of collecting the amount due with interest from the due date,which costs include attorneys fee of 33 1/2 % of the amount due and all costs expended in collecting this medical bill.

____ Date: ____________________________
Patient Signature

____
Witness

Electronic Payment

As a medical practice our goal is to provide you with the best medical care available in a positive environment. As a small business we must consistently strive to reduce and minimize our expenses and costs of operating a practice. With insurance plans ever changing and becoming more complicated for patients and billing specialist alike, it can become quite confusing. What the patient is actually responsible for once insurance pays its portion, is a combination of the individual's co-payment, co-insurance or deductible.

In an effort to facilitate this system we are asking every patient to provide us with a credit card or debit card at the time of service. The only amount charged to your credit or debit card will be the "Patient Responsibility" portion as stated on your EOB. You will not be charged until your insurance company pays its portion. This will reduce the cost of multiple statements and collection expenses. We are incorporating the same system used in businesses such as hotels and rental companies and will soon be standard practice for most hospitals, clinics, and private practices.

If a credit/debit card is not available you will be required to make a retainer deposit of $200.00 prior to being seen. This is not considered as a down payment towards your bill.

Charges to the authorized card will only be "Patient Responsibility" as stated on the EOB, if you feel that the "patient responsibility" is inaccurate you must resolve this issue directly with your insurance company. You will receive a Bill of Receipt once the "patient responsibility" portion has been charged to your card. You may also receive email notification with the amount charged to your credit/debit card.

Patient Name:________________________________ DOB:_________________________

Credit/Debit Card Number:_________________________ Exp Date:______________________

V-Code/Security Code:_________________ Visa or Mastercard (circle one)

Email (optional):__________________________________

I authorize Genis Women's Care, PC to charge my credit/debit card with the patient responsibility portion of my EOB.

Signature:____________________________________ Date:__________________________

*Please have card out for verification

Genis Women's Care,PC
2790 Godwin Blvd. # 375
Suffolk,Va 23434
(757) 923-4500
(757) 923-4607, Fax

Notice of Office Policies

Effective August 1, 2003 the following policies will be force for Genis Women's Care, PC

Due to recent insurance changes we will be asking you to show verification of insurance on each visit. This will apply to new and established patients.

Co-Payments are due at the time of your visit and will not be billed. A co-payment is an agreement that was made between you and your insurance company at the time your policy was established. If you **DO NOT** have your copay at time of visit, you will need to reschedule your appointment.

For all **OB/GYN** patients that have applied for Medicaid but have not yet been approved, you must show proof that you have Medicaid pending. A letter from your social working stating the date applied for Medicaid and how long it will take for your case to be approved will be sufficient letter **MUST** be supplied on your first visit. If you do not have a Medicaid card or another letter from your social worker by the second visit we will ask that you begin making payments or seek prenatal care elsewhere.

Payments for all patients with no insurance are due at the time of visit. .

********There are NO exceptions*********

There is a 15 minute span beyond your scheduled appointment time allowed.
If you arrive past the 15 minutes allowed you will need to reschedule.
If you are scheduled for an Ultrasound you must arrive on time, there is not a 15 minute allotment for these appointments.

In order to be well informed for any responsibilities (Deductibles/copayment) and to be sure it is covered under your policy for upcoming surgeries, procedures or prescriptions it is advisable, that YOU as a policy holder, call your insurance company prior to your office visit to verify benefits and coverage.

***By signing this I acknowledge that I have read and understand the terms of the office policies for Genis Women's Care, PC.

____
Patient Signature

____
Date

Genis Women's Care, PC
2790 Godwin Blvd # 375
Suffolk, VA 23434

ACKNOWLEDGEMENT OF RECIEVING NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given a copy of Genis Women's Care, PC's Notice of Privacy Practices. I have had any questions that I may have about the policy answered prior to signing this form.

I realize that this allows the release of my protected health information for the reasons of: treatment, payment and operation as well as other specified reasons. I agree that this agreement between Genis Women's Care, PC and I will remain in effect until I provide written revocation to Genis Women's Care, PC.

I give Genis Women's Care, PC permission to leave a message pertaining to Insurance benefits, coverage, and upcoming scheduled appointments on my answering machine or voice mail.

( ) Yes ( ) No

____
Signature of Patient/Legal Guardian

____
Date

Attention all Patients with Medicaid

You are responsible for letting us know when you have chosen an HMO. You will be asked to choose from OPTIMA, HEALTHKEEPERS or VA PREMIER.

We DO NOT accept VA PREMIER.

Your Insurance is your responsibility, please keep us informed if and when you receive an HMO.
Any denials received from Insurance due to not updating your Medicaid or HMO status will be your responsibility.

Patients or Guardian's Signature: ____________________________________

Date: __________________

Genis Womens Care, P.C.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact our Privacy Contact:
Lisa Perry, RNC, WHNP.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by mail, or you may request one at the time of your next appointment.

1. **Uses and Disclosures of Protected Health Information**

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by our office to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment, and health care operations by signing the consent, our office will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your provider, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your

protected health information may also be used and disclosed to pay your health care bills and to support the operation of this practice.

Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example your protected health information may be released to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information at times to another health care provider who, at our request, becomes involved in your care by providing us assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this practice. These activities include, but are not limited to: quality assessment activities, employee review activities, training of students, licensing, marketing and fund raising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to students that see patients at our office. In addition, we will call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party business associates that perform various activities (e.g. billing services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for

other marketing activities. For example, your name and address may be used to send you a newsletter about the practice and the services we offer, or to send a Christmas letter. We will also send your normal pap smear results to your home address, along with any other normal test results.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your provider or this practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization, or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved In Your Health care: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that persons involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general health, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your provider shall try to obtain your consent as soon as reasonably possible after the delivery of treatment. If your provider is unable to obtain your consent, we will still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your provider attempts to obtain consent from you, but is unable to do so due to substantial communication barriers, and the provider determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent Authorization, or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so tong as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practices premises) and it is likely that a crime has occurred.

Researchers: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers Compensation: Your protected health information may be disclosed by us as authorized to comply with workers compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your provider created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that your provider and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny

access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record. .

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your provider does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your provider.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an
alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your provider amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in the Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

You have the right to obtain a copy of this notice from us upon request

3. Complaints

You may complain to us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. You also have the

right to complain to the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, Lisa P. Perry at 923-4500 for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an