Girls to Women
HEALTH AND WELLNESS

PATIENT DEMOGRAPHIC and INSURANCE INFORMATION **DATE: ____/____/________**

____________________	____________________	____________________	__________________
Last Name	First Name	(Nickname, if applies)	Date of Birth

____ ____________________ __________________
Address City and State Zip

Home Phone: _______________ **Patient** Cell: ________________ **Patient** Email (optional): ________________________________
(May we send our email newsletters? ___Yes ___No)

How were you referred to our practice? __________________________ Appointment O Rubin-Remer O Sugerman O Musacchio

PARENT(S)/GUARDIAN(S) INFORMATION

Name: ____________________ Relationship to Patient: _________ Address: _______________________City: __________State/Zip: ___________

Home Phone (if different): ___________________ Cell Phone: ___________ Work: ________________ Email contact: ________________________
(May we send our email newsletters? ___Yes ___No)

Name: ____________________ Relationship to Patient: _________ Address: _______________________City: __________State/Zip: ___________

Home Phone (if different): ___________________ Cell Phone: ___________ Work: ________________ Email contact: ________________________
(May we send our email newsletters? ___Yes ___No)

Please note any custody arrangements or guardianship: ____

OTHER EMERGENCY CONTACT: ____ Phone: _______________ Relationship: ______________

PHARMACY ____ _________________________ _______________________
Name (and cross streets if known) Pharmacy Phone (if known) Pharmacy Fax (if known)

INSURANCE INFORMATION

Subscriber Name: ____ DOB: ________________ Relationship to patient: __________________

Insurance Company: __________________________ Phone #: _______________ Member ID: _____________________ Group#: ______________

Address:_________________________________City: _____________ State: ______ Zip: _______

Effective date: __________________________ Copay: __________ Deductible: ____________

Authorization for Release of Information to Insurance and Assignment of Insurance Benefits

I hereby authorize release of information to ______________________________Insurance Company and assignment of insurance benefits to Girls to Women Health and Wellness, PA, Drs. Rubin-Remer, Sugerman, and Musacchio, as this information may be necessary for the completion of my medical claims. I understand I am financially responsible for all charges not covered by my insurance company.

____________________________________	____________________________________	_____/_____/______
Patient Name (print)	Patient Signature (adult patients only)	Date
____________________________________	____________________________________	_____/_____/______
Responsible Party (print) (if patient is a minor)	Responsible Party Signature (if patient is a minor)	Date

General Office Policies and Procedures

Appointment Types. We offer two kinds of appointments: 1) preventive/well care and 2) sick/problem visits. We appreciate your understanding that we cannot accommodate both needs during the same appointment. Significant or multiple medical concerns noted at preventive/well visits may require rescheduling the patient to come back at a separate time.

Appointment Times. Please arrive **15 minutes** before your appointment with **PATIENT FORMS COMPLETED.** If unable to complete forms in advance, please arrive 30 minutes prior to your scheduled appointment.

Record Releases. To facilitate care, please provide copies of immunization records and any pertinent medical summary information (medical history, growth charts, laboratory studies, results of important medical consultations, hospital records, etc) *in advance of your appointment whenever possible.* Please use our **Record Release** form to have records sent from other providers as necessary.

Parents of Minors. Both patients and their parents may be invited to the examining room to meet with the physician for new appointments. *However, parents may be asked to return to the waiting room during the medical examination and evaluation.*

Minor Consent. In Texas, minors 17 years or younger may independently consent to evaluation and medical treatment for sexually transmitted infections and pregnancy (but not pregnancy prevention) and to counseling for 1) suicide prevention; 2) chemical addiction or dependency; or 3) sexual, physical, or emotional abuse.

Minor Confidentiality. We encourage patients to involve parents in their lives and in important health decisions. If patients require or request confidentiality, we will honor their wishes to the extent allowed by law.

Adult Patients. By law, we cannot disclose protected health information to parents/guardians of adult patients (ages 18 and above) without specific consent from the patient. Parents/guardians are invited to inform physicians and medical staff of their concerns as appropriate, but please understand our limitations in providing reciprocal information without direct written consent of the patient. We request that all established patients resubmit paperwork, including consent to disclose information to parents, upon turning 18.

School/Camp forms, disability forms, letters to insurance companies, copies of medical records, etc., are not a free service and will be charged for at the time the forms and/or letters are requested by the patient/parent and/or guarantor on the account.

> **Courtesy Notice: Annual Physical Examination Forms (for school, camps, and other programs).** Upon request, GTW physicians are happy to complete standard UIL (University Interscholastic League) physical forms *at the time of a scheduled annual physical (wellness check-up)* appointment without additional charge. Many schools/camps will accept these forms within 6-12 months of the required completion date. Thank you for understanding that completing forms outside of scheduled annual visits requires staff and physician time; fees will be charged for form completion in accordance with our Financial Policies ($15 per form).

Follow-up Appointments. To best accommodate your scheduling preferences, please schedule your recommended follow-up visits at the time of checkout, particularly if you prefer late afternoon or early morning appointment times.

Medication Refills. Please allow 48 hours for all refill requests left on our nurse line or which are faxed in from your pharmacy. Understand that some prescriptions require office visit prior to being refilled.

After-hours Calls. Please limit after-hours phone calls to emergencies only. If you have non-emergent concerns, we will be happy to find time to work you in for an appointment during office hours. All refill requests will be handled during business hours only.

Telephone Calls and Emails. We appreciate your cooperation in providing detailed information to our clinical staff to best facilitate a timely response to your concerns. All non-urgent messages will be returned within the next 24-business hours. Emails sent to staff or physicians through our gtw-health.com domain are not encrypted and cannot be assured to meet HIPPAA confidentiality requirements; please use email only for non-urgent, non-confidential concerns. We encourage you to use our Patient Portal, which will allow confidential and secure electronic communication (please contact our staff for more information on this option).

Telephone/Email Fees. There is a charge for telephone or email treatment that avoids an office visit (during and after office hours). This does not include calls related to a visit in the prior 7 days or which require an office visit in the next 24 business hours. These services are typically not covered by insurance plans. Guarantor and/or parent on the account is responsible for payment.

Parent Consultations. GTW physicians are happy to meet with parents to introduce them to our practice environment and philosophies at no charge. Parent meetings involving exchange of patient information will be charged as an appointment.

Cancelled/Missed Appointments. *No shows and appointments not cancelled 24 business-hours in advance of the scheduled time will be charged ($250 for new patients, $60 for established patients). Guarantor/parent on the account is responsible for payment.*

We look forward to serving your needs as efficiently as possible. Our practice manger, Tracy Miller, would be happy to answer any questions you have about these policies.

By signing here, I agree that I have read and understand these policies and agree to abide by them.

______________________________	______________________________	_____/_____/______
Patient Name (print)	Patient Signature (adult patients only)	Date
______________________________	______________________________	_____/_____/______
Parent/Guardian (print) (if patient is a minor)	Parent/Guardian Signature (if patient is a minor)	Date

Financial Policies and Advance Beneficiary Notice Regarding Covered vs. Non-covered Services

Insurance It is the responsibility of the guarantor and/or parent on the account to know his/her insurance plan. If you are unsure what your insurance will cover at any given office visit, please contact your insurance company for benefit and payment information.

- **In-Network Services** We have made prior arrangements with many insurers/health plans to accept assignment of benefits. We will bill these plans and require you to pay the authorized patient portion at the time of service.
- **Out-of-Network Services** If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare a claim for **you** to submit to your insurance. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- **Girls to Women will only file insurance claims to ONE primary insurance company.** We will provide you with a claim you can submit directly to your Secondary Insurance Provider. Your balance will reflect the balance after your primary has paid.

Co-pays, deductibles, outstanding balances are due and payable at the time of service. The guarantor and/or parent on the account is responsible for balances not covered/paid by your insurance plan. Any account that becomes delinquent may be subject to additional charges. **For all services rendered to minor patients,** the adult accompanying patient will be responsible for payment of the copy. **For patients not filing insurance or for predetermined NON-COVERED SERVICES, full payment is due at the time of service** unless other arrangements have been made in advance.

Telephone/Email Fees. There is a charge for telephone/email treatment that avoids an office visit (during or after office hours). These services are typically not covered by insurance plans. Guarantor and/or parent on the account is responsible for payment.

School/Camp forms, disability forms, letters to insurance companies, copies of medical records, etc., are not a free service and will be charged for at the time the forms and/or letters are requested by the patient/parent and/or guarantor on the account. (Courtesy Notice: Upon request, GTW physicians will complete standard UIL physical forms at the time of a scheduled annual physical/wellness exam without additional charge.)

Cancelled/Missed Appointments. *No shows and appointments not cancelled 24 business-hours in advance of the scheduled time will be charged ($250 for new patients, $60 for established patients). Guarantor/parent on the account is responsible for payment.*

Credit Cards. As a convenience to our patients, we accept VISA, MasterCard, American Express, and Discover.

ADVANCE BENEFICIARY NOTICE regarding COVERED VS. NON-COVERED SERVICES Health insurers do not necessarily pay for all of your health care costs. Insurance only pays for **covered items and services**. Coverage varies by diagnosis, service provided, and terms of benefits arranged by individual or employee sponsors of each plan. The fact that insurance may not pay for a particular service does not mean that you should not receive it, if your doctor recommends that you do receive this service; it is always your choice. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. In the event that insurance denies payment for a non-covered diagnosis or a non-covered service, the patient will be responsible for full payment, due upon receipt of a statement from our office. By signing below you agree to take financial responsibility for the cost of the item(s) or service(s), if your health insurance does not include this as a covered item(s) or service(s). We may require a credit card number on file to charge for services deemed not covered by your insurance. Your health insurance may not pay for the item(s) or service(s described below:

Item	Cost
• Missed appointments / no shows (established patients)	$60 (established patients), $250 (new patients)
• Medical assessment or advice provided by telephone or email by nurse or physician	$15-75
• Routine Annual Physicals or other Preventive Health services	$175-300
• Extended time (physician office visit greater than 1 hr, each additional 30-60 min)	$240-300
• Completion of documents, letters or forms	$15 ea (unless at time of annual well examination)
• Review of records, coordination of care between specialists	$60-150
• Parent/Family consultation when patient not present	$90-300
• Medical nutrition therapy provided by physicians, nurses, or licensed dietitians	$50-150
• Mental health counseling services provided by physicians, nurses, or licensed therapists	$150-200
• Group appointments or classes	$15-80
• Immunizations (If you cannot afford your child's immunizations ask us about Texas Vaccines for Children.)	variable
• Books, CD/DVDs, educational materials, fitness equipment, medical products	variable

I have read, understand, and agree to the financial policy of this practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility and are due at time of service.

______________________________	______________________________	_____/_____/______
Patient Name (print)	Patient Signature (adult patients only)	Date
______________________________	______________________________	_____/_____/______
Responsible Party (print) (if patient is a minor)	Responsible Party Signature (if patient is a minor)	Date

Girls to Women
HEALTH AND WELLNESS

AUTHORIZATION AND CONSENT TO TREAT (for patients <18 years of age)

I, __________________________, the natural parent/legal guardian of __________________________ (a minor), have the legal right to consent to medical and surgical treatment for this patient. I grant my permission for treatment at Girls to Women Health and Wellness by a licensed physician, licensed nurse practitioner, and/or designees, including such personnel as the physician may deem necessary. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. I grant permission for treatment provided according to generally accepted standards of medical practice.

I understand that, in Texas, only physicians and clinics receiving Federal Title X funding can provide contraceptive services without parental consent. *My **initials** here indicate that I* ___**do** or ___**do not** *consent to contraceptive prescription (including emergency contraception) for my minor child if she requests it.*

This consent will be in effect from this date until minor is 18 years of age unless cancelled earlier by me in writing.

___________________________	___________________________	_____/_____/______
Patient Name (print)	Patient Signature (adult patients only)	Date
___________________________	___________________________	_____/_____/______
Parent/Guardian (print) (if patient is a minor)	Parent/Guardian Signature (if patient is a minor)	Date
___________________________	___________________________	_____/_____/______
Witness Name	Witness Signature	Date

DELEGATION OF CONSENT

I hereby authorize the following individual(s):_______________________________, whose relationship to this child is ___________, to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a health care provider licensed in the state of Texas. This consent includes, but is not limited to, medical and surgical intervention, and elective as well as emergency care as specified above. This delegation shall be valid until I withdraw delegation of consent.

___________________________	___________________________	_____/_____/______
Patient Name (print)	Patient Signature (adult patients only)	Date
___________________________	___________________________	_____/_____/______
Parent/Guardian (print) (if patient is a minor)	Parent/Guardian Signature (if patient is a minor)	Date
___________________________	___________________________	_____/_____/______
Witness Name	Witness Signature	Date

Girls to Women
HEALTH AND WELLNESS

Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Girls to Women Health and Wellness, PA to use and disclose protected health information (PHI) about me (or my minor child) to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Girls to Women Health and Wellness, PA describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent. Girls to Women Health and Wellness, PA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Tracy Miller, the privacy officer for Girls to Women Health and Wellness, PA.

With this consent, Girls to Women Health and Wellness, PA:

O MAY O MAY NOT ***call my home and/or other prior designated alternative location and leave a message on voice mail or in person*** in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

O MAY O MAY NOT ***call my CELL (MOBILE) PHONE and/or other prior designated alternative location and leave a message on voice mail or in person*** in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

O MAY O MAY NOT ***mail to my home and/or other prior designated alternative location*** any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

O MAY O MAY NOT ***e-mail to my home and/or other prior designated alternative location*** any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Girls to Women Health and Wellness, PA restrict how it uses or discloses my (or my minor child's) PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to allow Girls to Women Health and Wellness, PA to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, in writing, Girls to Women Health and Wellness may decline to provide treatment to me (or my minor child).

______________________________ ______________________________ _____/_____/______
Patient Name (print) Patient Signature (adult patients only) Date

______________________________ ______________________________ _____/_____/______
Parent / Guardian (print) (if patient is a minor) Parent / Guardian Signature (if patient is a minor) Date

Release of Information to Parent / Guardian FOR ADULT PATIENTS (18 YEARS OF AGE OR OLDER)

I, ___________________________, authorize Girls to Women Health and Wellness to discuss/release the following protected health information to my parent(s)/guardian, named below, whether by phone, email or regular mail, as follows: (please check one only)

☐ **Any and all protected health information (*this may include sexual health, mental health and HIV/AIDS information)*** pertaining to the medical care I received at or through Girls to Women Health and Wellness

☐ Specific medical condition(s) (please state): ____

☐ Medical care I received at or through Girls to Women Health and Wellness during the following dates:

____________________________ to ____________________________

I authorize this information to be released to: ____________________________ and/or ____________________________
Print name of parent/guardian Print name of parent/guardian

This authorization is to be in effect until such time as I revoke it in writing.

___________________________________ ___________________________________ _____/_____/______
Patient Name (print) (adult patients only) Patient Signature (adult patients only) Date

___________________________________ ___________________________________ _____/_____/______
Witness Name (print) Witness Signature Date

CONSENT TO OBTAIN AND/OR RELEASE MEDICAL RECORDS

____________________	____________________	____________________	____________________
Patient Last Name	First Name	(Nickname, if applies)	Date of Birth

____	____________________	____________________
Address	City and State	Zip

Home Phone: ____________________ Patient Cell: ____________________

The purpose of this disclosure is: __ at my request __ for continuing health care __ other:

PLEASE RELEASE MY MEDICAL RECORDS FROM [ ] TO [ ]:

________________________________	____
Name	Address, City, State, Zip
________________________________	____
Phone	Fax

RECORDS TO INCLUDE THE FOLLOWING:

[ ] All MEDICAL Records	[ ] Records dated ____ to ____
[ ] Immunization Records	[ ] Medical Summary (if applicable)
[ ] Growth Charts	[ ] Consult Notes
[ ] Lab Reports	[ ] Psychological Records
[ ] Radiology Reports	[ ] Other (please specify):

[ ] Communication between providers as needed including medical and psychological record information

PLEASE RELEASE MY MEDICAL RECORDS FROM [ ] TO [ ]:

Girls to Women Health & Wellness, 17300 Preston Road, Suite 160, Dallas, TX 75252 Ph: 972-733-6565 F: 972-733-6564

RECORDS TO INCLUDE THE FOLLOWING:

[ ] All MEDICAL Records	[ ] Records dated ____ to ____
[ ] Immunization Records	[ ] Medical Summary (if applicable)
[ ] Growth Charts	[ ] Consult Notes
[ ] Lab Reports	[ ] Psychological Records
[ ] Radiology Reports	[ ] Other (please specify):

[ ] Communication between providers as needed including medical and psychological record information

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation will be effective upon receipt by Girls to Women Health and Wellness, PA. I have read and understand the terms of this Authorization, and hereby knowingly and voluntarily authorize Girls to Women Health and Wellness, PA to use or disclose my health information in the manner described above.

________________________________	________________________________	_____/_____/______
Patient Name (print)	Patient Signature (adult patients only)	Date
________________________________	________________________________	_____/_____/______
Parent/Guardian (print) (if patient is a minor)	Parent/Guardian Signature (if patient is a minor)	Date