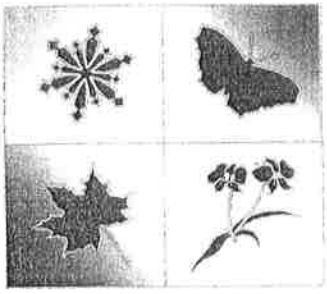


FOUR SEASONS WOMEN'S HEALTH

OBSTETRICS AND GYNECOLOGY

2017 Rickety Lane, Tyler, TX 75703
(903) 533-8811 ■ Fax (903) 593-5511

Patient Information

Last:_____ First:_____ M.I._____

Date of Birth:_____ S.S. #_____

Mailing Address:_____ City, State, Zip:_____

Home Phone:_____ WorkPhone:_____ Mobile:_____

Email Address:_____ Marital Status: M S W D Race:_____

Employed by:_____ Family Physician:_____

Preferred Pharmacy:_____

Emergency Contact:_____ Relationship_____

Emergency contact Phone:_____

Primary Insurance Co:_____ Address:_____

ID#_____ Group#:_____

Subscribers Name:_____ Subscribers Date of Birth:_____

Subscribers Employer:_____ Relationship to you:_____

Secondary Insurance Co:_____ Address:_____

ID#_____ Group#:_____

Secondary Subscribers Name:_____ Subscribers Date of Birth:_____

Secondary Subscriber Employer:_____ Realtionship to you:_____

Email: I give permission to Four Seasons Women's health to send me email messages regarding upcoming appointments. We will not sell or distribute your email address to any other entity.

Initial:_____

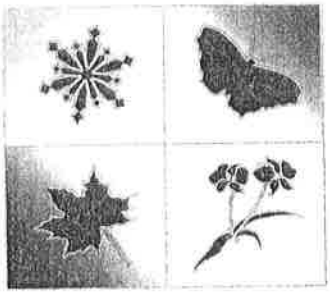
Notice of Privacy Practice: Your personal health information (PHI) is protected and is used exclusively to administer medical services and process your claims. Unauthorized disclosure of PHI is strictly prohibited. A complaint can be filed with the Privacy Officer in person or in writing at any time you feel your PHI is not being protected and the complaint will be met with full respectful attention without retaliation.
Our notice of Privacy Practices is located at the front desk. We are happy to give you a copy if you would like copy for your records. This describes in more detail how your health information may be used and disclosed, and how you can access your information.

Initial:_____

I consent to treatment at Four Seasons Women's Health. If the patient is a minor, I herby authorize treatment as the parent or legal guardian.

Printed Legal Guardian_____ S.S#_____

Signature_____ Date_____



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FINANCIAL RESPONSIBILITY: As a courtesy to you, Four Seasons Women's Health will bill your insurance carrier, however you are ultimately responsible for payment of services you receive whether or not paid by your insurance. Four Seasons Women's Health will verify your benefits, but this is in no way a guarantee of payment. It is your responsibility to know your policy coverage.

Initial:_____

I understand that I am financially responsible for all co-pays, deductibles, and any co-insurance balances due per my contract with my insurance provider, and for any balance not paid by my insurance provider. I understand that I am obligated to remit any payments made by my insurance directly to me, to Four Seasons Women's Health as soon as they are received. I agree to pay for all collection cost incurred by Four Seasons Women's Health in the collection of any balance I owe.

Initial:_____

Authorization is hereby granted to release all information contained in my medical records to my medical insurance company. This may contain information regarding communicable disease, such as Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV).

Initial:_____

It is not our intention to cause undue financial hardship; however, in order to maintain our standard of care, we must collect our receivables as efficiently as possible. All patient balances, required by your insurance, are due at the time of each visit.

NO SHOWS/LATE CANCELLATIONS: Four Seasons Women's Health strives to provide all our patients with the best possible care. In order to provide this care for you to achieve your goals for recovery, it is essential that you keep all scheduled appointments

- In order to do this, we are requesting that you provide us with a 24 hour cancellation notice. Failure to provide this notice prevents us from helping other patients during the time that you did not use. **Therefore, failure to provide us with 24 hour notice will result in a charge $25.00 for each missed visit.** This missed appointment fee is not covered by your insurance plan and will be billed to you directly.

  Initial_____

- Additionally, if a patient is 15 minutes late to his/her appointment, we reserve the right to cancel/ reschedule the appointment.

  Initial_____

- If multiple appointments are missed or rescheduled and we identify a problem with you keeping appointments, Four Season Women's Health will not be able to provide care for you at this office.

  Initial:_____

By signing this agreement, it is understood that you, or as the guardian of a minor, understand and agrees to abide by our patient financial policy and accepts the conditions thereof.

Signed_____ Date:_____

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information. Additionally, I authorize the release of my medical information to the following.

_____

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient: _____ Date:_____

Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____Date:_____