

Women's Specialty Care, P.C
682 Hemlock Street
Suite 300
Macon GA 31201
478-744-9683

TO OUR CURRENT PATIENTS

We know that things change from year to year and in an effort to make sure all of our information is current, we ask that you bring the following information to your next scheduled appointment:

- Your insurance card. Due to HIPPA violations, our office can no longer look up your insurance information online. If your card does not contain the address and phone number of your carrier, please obtain this information and bring it with you. Failure to supply this information will result in your paying for your visit and being reimbursed after we obtain the information.
- IF you have secondary insurance, we will also need this information in order to coordinate your benefits
- IF your address or telephone numbers have changed, please give your updated information to the check-in desk.

ALL co-pays and unmet deductibles are due and payable at the time of your visit. If you do NOT have insurance OR if we do not participate with your insurance company, you will be responsible for your entire bill at the time services are rendered unless other financial arrangements are made prior to your visit. If you have questions or concerns, please contact our office before your appointment.

As always, if you need to cancel or change your appointment, please give us at least a 24 hour notice. There may be a charge for missed appointments.

****KNOW YOUR LAB****

If you do not know what lab your insurance company participates with, please call your insurance company before your appointment.

****APPOINTMENT TIME****

In order to help us expedite your appointment time, please have the attached paperwork completed upon arrival to our office.

Visit us at: www.wscmacon.com

Women's Specialty Care P.C.

OBSTETRICS & GYNECOLOGY

PATIENT CONFIDENTIALITY RELEASE DOCUMENT

Name _____ Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Email Address _____

I, _____, Date of Birth _____, give my permission for the following person(s) listed below to have access to my medical records, including test results, appointment information, information regarding my care and other types of records. This includes billing and insurance documentation.

_____ Relationship to patient _____

_____ Relationship to patient _____

_____ Relationship to patient _____

I, _____, give permission to Women's Specialty Care P.C. to leave *confidential messages* regarding my health information at:

My home number: _____

My work/cell number: _____

THIS RELEASE IS VALID UNLESS REVOKED

Signature _____ Date _____

MEDICAL HISTORY UPDATE

Name _____ Date of Birth _____

Pharmacy _____ City _____ State _____

Please list any surgery, hospitalizations, procedures or new medical problems since your last visit:

Any changes in your family history? (Breast or colon cancer? Diabetes?)

Current Medications (include birth control, hormones, non prescription drugs and vitamins):

List all drug allergies:

List all Physicians from whom you receive medical care:

Date of last tetanus shot? _____ Date of last flu shot? _____

Date and results of last mammogram? _____

Date and result of last colonoscopy? _____

Date and result of last cholesterol test? _____

Do you smoke? _____ Drink alcohol? _____ Use recreational drugs? _____

Frequency and type of exercise? _____

Are you sexually active? _____ Number of sexual partners in last 2 years: _____

What do you use for birth control? _____

When was your last menstrual period? _____

Please list any problems or concerns you would like to discuss:

Signature _____ Date _____



CENTRAL GEORGIA HEALTH EXCHANGE

The next generation of patient information

Permission to Create a Health Exchange record and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange* and this permission form.

Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record

No, I do not agree to participate in the Central Georgia Health Exchange electronic medical record

Printed Name of Patient

Patients Date of Birth

Printed Name of Representative

Signature of Patient or Representative

Date

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis (Relationship to Patient): _____

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; ; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet, "A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (<https://www.CGHE.net>) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Health Exchange, 777 Hemlock Street, Hospital Box 98, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) through the *Central Georgia Health Exchange*.

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**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR
TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS**

I, _____, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plan for future care of treatment. I also understand the practice utilizes electronic prescribing technology and may obtain information regarding my medication history from SureScripts, which is a national provider of electronic prescribing services connecting physicians and hospitals with pharmacies.

I understand that this information serves as:

A basis for planning my care and treatment

A means of communication among the many health professionals who contribute to my care.

A source of information for applying my diagnosis and surgical information to my bill.

A means by which a third-party payer can verify that services billed were actually provided, and

A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing the consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I fully understand and accept/decline the terms of this consent.

Patient Signature

Date