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 regulations, 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

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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. The practice also obtains information regarding my prescription history through Sure Scripts, a national provider of electronic prescribing services connecting physicians and hospitals with pharmacies. My information will be shared with GRAChIE, a network that connects practitioners and healthcare settings across Georgia unless I choose to opt out of this service.

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 this consent. I understand that Women's Specialty Care reserves the right to change its notice and practices at any time and I can access the most up to date version online at www.wscmacon.com. 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. To opt out of the health exchange in Georgia, I understand that I can do so by visiting www.grachie.org or I can obtain an opt-out form from my provider. 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 the terms of this consent.

____ _________________________________

Patient Signature Date

Women's Specialty Care P.C.

O B S T E T R I C S & G Y N E C O L O G Y

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 ___________ Phone # __________________

_______________________ Relationship to patient____________ Phone# __________________

_______________________ Relationship to patient____________ Phone# __________________

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 ______________