WILLOW
WOMEN'S HEALTH

2840 Legacy Drive, Suite 400
Frisco, Texas 75034
P: 469-476-5623 F: 469-476-5624

New Patient Form

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Patient Information

Name (*First, M.I., Last)*: _____ Date of Birth: _____ Age: _____

Social Security #:_____ Marital Status: _____ Phone: _____

Preferred Language: _____ Ethnicity:_____ Race:_____

Address: _____

E-mail Address: _____ How did you hear about us?_____

Referring Physician/PCP: _____

Preferred Pharmacy Name & Address: _____

Emergency Contact

Name: _____ Relation: _____ Phone: _____

Responsible Party

Name: _____ Relationship to Patient: _____ D.O.B.: _____

Address: _____ Phone: _____

Insurance Information

Insurance Company: _____ Do you have insurance? ☐ Yes ☐ No

Are you the policy holder? ☐ Yes ☐ No

If no, what is the relation to the policy holder?: Spouse / Dependent / Other: _____

Policy Holder's D.O.B.: _____ Policy Holder's Phone: _____

Address: _____

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CONSENT FOR TREATMENT - FINANCIAL RESPONSIBILITY

I, the undersigned, consent to treatment necessary for the care of the above-named patient. I hereby authorize release of any or all medical records to referring physicians, my insurance carriers, or those involved in payment of my account. I give Willow Women's Health, LPC. and its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call, text message, or e-mail), for the purpose of treatment, insurance, unpaid balances, and/or payment.

I further acknowledge full financial responsibility for any services rendered by Willow Women's Health, LPC. and understand that payment of charges incurred in the office is due at the time of service. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to Willow Women's Health, LPC. In the event an account is not paid within 90 days, the undersigned agrees to pay all costs of collection including attorney's fees and court costs (33%) and hereby waives all right of exemption under the constitution of the State of Texas.

Your physician is here to provide you with the best care possible. If services that your physician feels necessary for the treatment of your condition and maintenance of good health are NOT covered by your insurance health benefits contract, you are expected to pay for those services in full. If you have any questions about whether or not a particular service is covered by your health benefits contract, someone in our office will be happy to assist you.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the physician's office manager. Please sign below that you have read and agree to this financial policy.

Patient Signature: _____ **Date:** _____
(or Responsible Party, if applicable)

Patient Signature: _____ **Date:** _____
(Co-Responsible Party, if applicable)

HIPAA

• **Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.

• **Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by visiting our website: www.doctorbewell.com or contact the Willow Women's Health office you are receiving services from.

• **Changes to This Notice We reserve the right to change this Notice.** We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office.

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• **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Willow Women's Health, Privacy Officer, at the address listed at the beginning of this Notice or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Humans Services, 200 Independence Ave., S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775 or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. You will not be penalized for filing a complaint.
Notice Effective 10/31/2016

Willow Women's Health
ACKNOWLEDGEMENT OF RECEIPT OF
PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the Willow Women's Health Patient Notice of Privacy Practices effective October 31, 2016.

Patient Signature: _____ Date: _____
(or Guardian, if applicable)

****

In complying with HIPAA, we want to make sure that we guard your privacy according to your wishes when it comes to family, friends, and co-workers. Please answer the following questions:

May we leave a message on your voicemail? ☐ Yes ☐ No

May we leave a message at your work? ☐ Yes ☐ No

May we discuss appointment reminders with other adults who answer your phone? ☐ Yes ☐ No

Disclosure to Designated Family and/or Friends

If there is anyone you would like Willow Women's Health to disclose your HPI to, please list them below:

NAME	RELATIONSHIP	ITEMS TO DISCUSS
		☐ Medical Care ☐ Appointments ☐ Financials ☐ All information
		☐ Medical Care ☐ Appointments ☐ Financials ☐ All information
		☐ Medical Care ☐ Appointments ☐ Financials ☐ All information

Patient Signature: _____ Date: _____

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Release of Information

Patient Name: _____

Previous Names Used: _____

Date of Birth: _____ Social Security Number: _____

I hereby authorize: ☐ Shruti Benjamin, M.D.

To obtain medical records from:

Physician or Business Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

To release medical records to:

Physician or Business Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Information to be requested or released is for the following purposes:

☐ Treatment ☐ Record Review ☐ Transfer of Care

☐ Patient Request ☐ Referral ☐ Other: _____

This authorization is valid for 90 days from the date below or _____, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

Patient Signature: _____ **Date:** _____

Guardian's Signature: _____ **Date:** _____
(if patient is a minor)

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OFFICE POLICIES

Please read each office policy carefully. We hope this information is helpful to you when accessing our office and making decisions about your health.

Registration: All patients are required to complete a patient information form and present a valid form of identification along with their insurance card before being seen by a provider.

Charges: Full payment is due at the time of service unless other payment arrangements have been made. Copays, deductibles, co-insurance, and balances are also expected at the time of service. Delays in insurance occur when insurance information is not provided in a timely manner. Such delays may also result in insurance not covering the services provided. **When an insurance company denies payment for a service, it is the patient's responsibility to cover the charges. Therefore, it is important to review your benefits with your insurance provider. In the event your insurance plan determines a service to be "a non-covered service", you will be responsible for all non-covered and allowable charges.**

No Show/ Cancellation: Patients with two (2) no show appointments will be charged a $25.00 fee and receive a no-show letter. Patients who do not give a 24-hour cancellation notice or cancel at the last minute may also be charged a $25.00 fee. This fee is not payable by your insurance company. Our office attempts to make courtesy reminder calls, however, we cannot always provide this service. It is the patient's responsibility to remember about their appointment time and date. Patients who have three no shows will be subject to dismissal.

Late Arrivals: Patients who arrive ten (10) minutes past their appointment time may be rescheduled for another day.

FMLA/Disability Forms: Any patient needing forms to be filled out for FMLA or Short-Term Disability will be charged a $25.00 processing fee. This fee must be paid before the forms can be picked up, faxed, or mailed out. Please allow 5-7 business days for the forms to be filled out. This fee is not payable by your insurance company.

Medication Refills: Refill requests should be called into your pharmacy at least five (5) business days before the last pill is taken to allow adequate time for approval. Refills will only be handled during normal business hours, Monday through Friday. Narcotic prescriptions will not be refilled after hours or on the weekends.

Referrals: Please allow five (5) business days to process any non-urgent referrals.

Behavior: Physical and verbal abuse towards office staff will not be tolerated. This includes offensive behavior on the telephone with office personnel. Abusive behavior may result in immediate dismissal from the practice.

Patient Portal: While we encourage the use of the portal, please be aware that portal messages will NOT be answered after office hours, on weekends, or on holidays. Please use the main office phone number for emergencies/urgent matters.

Patient Signature: _____ **Date:** _____
(or Guardian, if applicable)

Printed Name: _____ **Date:** _____