Vineland Gynecology Associates
an Axia Women's Health Care Center

Patient Demographic Form

Please complete this form in order to ensure proper billing of your services.

Patient Information

Last Name: _____ First Name: _____ Today's Date: _____

Other Name: _____ Date of Birth: _____ Soc. Sec. No: _____

Address (street): _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PCP: _____ Ref. Physician (if different): _____

Address (street): _____ Address (street): _____

City, State, Zip: _____ City, State, Zip: _____

Telephone #: _____ Telephone #: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

Employment Information

Employer: _____

Employer Address (street): _____ City, State, Zip: _____

Emp. Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self-Employed ☐ Active Military

Student Status: ☐ Full Time Student ☐Part Time Student

Insurance Information

PRIMARY CARRIER NAME: _____ Telephone #: _____

Address: _____ City, State, Zip: _____

ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

SECONDARY CARRIER NAME: _____ Telephone #: _____

Address: _____ City, State, Zip: _____

ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

Parent / Guardian Information

Contact: _____ Relationship to You _____

Home Phone: _____ Alt. Phone: _____

Contact: _____ Relationship to You _____

Home Phone: _____ Alt. Phone: _____

Electronic Communications

Portal: We offer secure electronic communications between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

☐ Yes, I want to participate, please use the email provided on my HIPAA form.

☐ No, I do not wish to participate.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

Automated Calls: As an added convenience, we offer automated appointment reminders via a text message or an automated call for those who want to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for appointment reminders.

I understand under the telephone consumer protection act, that in order for you to contact me by automated means for services relating to my medical care, including appointment reminders, monies I may owe, etc., I agree that Axia Women's Health and/or your agents may contact me by my cell phone, which may result in charges to me. You may also contact me by text messages, or emails providing that I have consented above. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automated dialing device, as applicable.

☐ Yes, I agree to participate in automated dialing, my cell number is provided below.

Cell Phone Number: _____

☐ No, I do not wish to participate.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

Additional Information

Race: Which category best describes your racial background?

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Asian ☐ White

☐ Black or African American ☐ Unreported/Refused to Report

Ethnicity: How would you describe you ethnicity, such as your family background or ancestry?

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unreported/Refused to Report

Preferred Language: What language do you usually speak at home?

☐ English ☐ Spanish ☐ Other _____

How did you hear about our practice? ☐ Health Plan ☐ Internet ☐ Our Web Site ☐ ER/Hospital

☐ Newspaper/Magazine ☐ Patient _____ ☐ Other _____

Pharmacy Information

Pharmacy Name: _____ ☐ Local ☐ Mail away

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

Pharmacy Name: _____ ☐ Local ☐ Mail away

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

227 Laurel Road
Echelon One, Suite 300
Voorhees, NJ 08043
P (856) 669-6050

450 Cresson Blvd
Suite 300
Oaks, PA 19456
P (484) 831-0200

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HIPAA & REGISTRATION UPDATE FORM

(Please Print)

Date: / /	Primary Care Phys. (PCP):	PCP Phone No.:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	Gender: F M	Marital Status (circle one): Single / Mar / Div / Sep / Widow

Birth Date: / /	Age:	Social Security No.:	Home Phone No.: ( )	Cell Phone No.: ( )

Street Address:	City:	State:	Zip Code:

I authorize messages with medical information to be left on voicemail/answering machine at (check all that apply) ❑ Home ❑ Cell above.
I authorize: ❑ Brief message details to be left ❑ Extended message details to be left ❑ Restrictions:

PHARMACY INFORMATION

Local Pharmacy:	Address:	City:	State:
Mail-Order Pharmacy:	Address:	City:	State:

INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist.

Name of Primary Insurance Company:	Subscriber's Name:	Subscriber's SSN:	Subscriber's Date of Birth: / /

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Partner ❑ Other – please explain:

Name of Primary Insurance Company:	Subscriber's Name:	Subscriber's SSN:	Subscriber's Date of Birth: / /

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Partner ❑ Other – please explain:

IN CASE OF EMERGENCY

Name of contact:	Relationship to patient:	Home Phone No.: ( )	Cell Phone No.: ( )

RELEASE OF MEDICAL AND BILLING INFORMATION

I authorize the following individual(s) to receive information pertaining to any medical history, treatment received and billing matters:

Name:	Relationship to patient:	Birth Date: / /	Contact Phone: ❑ Home ❑ Cell ( )
		/ /	( )

PATIENT PORTAL COMMUNICATION

We continue to offer secure electronic communications between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information provided that we maintain your most up-to-date information. ***Do you wish to either continue to participate or sign up to participate?***

❑ Yes, I want to participate, my email is _____ ❑ No, I do not want to participate at this time.

MEDICAL CHAPERONE

I request a female chaperone to be present during my examination. ❑ Yes ❑ No ❑ Other (family member, partner, etc. will be present)

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my provider or insurance company to release any information required to process my claims.

_____ _____

Patient Signature *Date*

Vineland Gynecology Associates
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HIPAA
Acknowledgements and Authorizations

I. HIPAA Notice of Privacy Practices

Patient Acknowledgement

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review our Notice of our Privacy Practices:

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

II. Authorization for use or Disclosure of Health Information

Patient Contact Information

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

I authorize Brief messages with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐ Work

I authorize Extended messages with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐ Work

I authorize secure electronic communications be sent to my email address at: _____

Restrictions/Instructions: _____

Release of Medical History and Treatment Information

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name: _____ Relationship: _____ DOB: _____ Ph #: _____

Name: _____ Relationship: _____ DOB: _____ Ph #: _____

Restrictions: _____

Release of Billing Information

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

Name: _____ Relationship: _____ DOB: _____ Ph #: _____

Name: _____ Relationship: _____ DOB: _____ Ph #: _____

Restrictions: _____

Patient Acknowledgement

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office address. My revocation will be effective once received by the practice, an Axia Women's Health Care Center.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name: _____ Date: _____

Signature: _____ Relationship: _____

Additional Authorizations

Emergency Contact: _____ Relationship: _____ Phone: _____

I request a female chaperone to be present during my examination? ☐ Yes ☐ No ☐ Other _____

Vineland Gynecology Associates
an Axia Women's Health Care Center

Patient's Name: DOB:

Authorization for Treatment & Payment of Medical Benefits
Patient Financial Responsibility Form

Thank you for choosing our practice, an Axia Women's Health Care Center, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

Authorization for Treatment & Payment of Medical Benefits

I give permission to the practice, an Axia Women's Health Care Center, to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice, an Axia Women's Health Care Center.

Use of Photography

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

e-Prescription Consent for Medication History

With your consent, we may request and use your prescription medication history information using our e-prescription feature. This is for only informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

☐ Yes, I give consent to obtain my medication history using the e-Prescribing feature.

☐ No, I do not give consent to obtain my medication history using the e-Prescribing feature. I understand that my medication information may not be complete when making treatment decisions.

Patient Financial Responsibilities

- I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charge for the copying and distribution of patient medical records.
    - Charge for forms completion.
    - Charge for missed appointments.

Patient Authorizations

- By my signature below, I hereby authorize the practice, an Axia Women's Health Care Center, to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, an Axia Women's Health Care Center. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:

Signature of Patient or Guardian Date

Axia WOMEN'S HEALTH

227 Laurel Road
Echelon One, Suite 300
Voorhees, NJ 08043
P (856) 669-6050

450 Cresson Blvd
Suite 300
Oaks, PA 19456
P (484) 831-0200

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (HIPAA), as amended, is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your

home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization, or Opportunity to Object unless required by law. Use and disclosures of PHI for marketing purposes, as well as disclosures that constitute a sale of PHI, require an authorization from you.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. If such information is maintained in an Electronic Health Record (EHR), your access rights include the right to a copy in an electronic format. We have the right to charge you a fee for the copying of paper records, and in the case of a request for an electronic copy of your PHI maintained in an EHR (or a summary or explanation of such information) we have the right to charge you the amount of labor costs in responding to your request. Your right to inspect and obtain a copy of your PHI extends only to your PHI contained in our Designated Record Set for you. A "Designated Record Set" is the HIPAA term for medical and billing records and any other records that we use for making health care decisions about you.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Any such request for restrictions must be in writing, be addressed to the Privacy Officer, and state the specific restriction requested and to whom you want the restriction to apply. However, we are not required to comply with your request, unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information

you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. However, we may condition this accommodation by asking you for information as to how payment will be handled or a specification of an alternate address or other method of contact. We will not request an explanation from you as to the basis for the request. Your request must be in writing, be addressed to the Privacy Officer, and state the specific alternate means or location.

You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information contained in your Designated Record Set if you believe it is incorrect or incomplete. However, we are not required to make any such amendments. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. All of these documents will be placed in the appropriate part of your Designated Record Set. If you are requesting that we amend your records because you believe that you are a victim of medical identity theft, we will use reasonable efforts to assist you in making corrections to your record which are determined to be appropriate under the circumstances.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Affected individuals have the right to be notified in the event of a breach of unsecured PHI.

We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

To exercise any of your rights above, please contact our privacy officer in writing.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. **We will not retaliate against you for filing a complaint**.

This Notice was originally published and became effective on April 14, 2003, as amended from time to time.

Last Revision April 11, 2017

Vineland Gynecology Associates
an Axia Women's Health Care Center

Authorization to Release Medical Records

Patient's Name: DOB:

Patient's Address:

I, or my authorized representative, request that health information regarding my care and treatment be released as indicated below. I understand that:

1. My records may include information relating to alcohol and drug treatment, mental health treatment, and confidential HIV/AIDS and other sexually transmitted infection information unless excluded in section 7.
2. I have the right to revoke this authorization at any time in writing, unless action has already been taken on this consent.

3. Release To (name and address of provider):

Fax:( ) Phone:( )

4. Release From (name and address of provider):

Fax:( ) Phone:( )

5. Purpose for the Release of Records:

6. The information below may be disclosed from:

INSERT START DATE until INSERT STOP DATE

☑ All health information, except as follows (if checked and initialed):

Indicate the specific information **NOT** to be released and initial below.	Additional explanation/comments on information to be **WITHHELD,** if any.	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs		
☐ HIV/AIDS - related information		
☐ STI - related information		

7. If not the patient, name of person signing form:

8. Relationship to the patient:

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

Witness Statement/Signature: I have witnessed the execution of this authorization.

WITNESSES' NAME AND TITLE SIGNATURE DATE