Phone	Fax	Web
813.571.2777	813.571.2888	www.zwhealth.com

Zweibach Women's Health New Patient Packet

Thank you for choosing Zweibach Women's Health for your OB/GYN needs. You can fill out the following forms before your first visit. If you have any questions, feel free to call our office at 813.571.2777. We look forward to meeting you.

Thank you, and welcome to Zweibach Women's Health!

1. Welcome Letter
2. Patient Financial Responsibilities
3. Patient Registration
4. Summary of Privacy Practices
5. Patient Acknowledgment
6. Authorization for Use of Health Information
7. Release of Medical Records

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PATIENT FINANCIAL RESPONSIBILITIES

Thank you for selecting us for your care. We strive at all times to provide prompt, highly skilled, professional Board-Certified Ob/GYN care in a cost-effective manner.

Payments for professional services are usually due at the time services are rendered. We may assist you by sending a claim directly to your insurance carrier, in which case benefits will be assigned and payable to Zweibach Women's Health. Your insurance carrier will make payments on your behalf. You will remain responsible for any amounts not covered by your insurance carrier.

Our standard office procedure is to bill all insurance carriers within one week from the time services are provided. Typically, most carriers will pay us within 30 days. When we do not receive payment or some other advice within 45 days, we send out a duplicate bill. After 60 days, if payment is still not received, we assume that the carrier will not pay on your behalf and we will bill you for total charges rendered. We expect payment in full within 10 days.

Please be assured that at all times we will work with you in trying to resolve any payment issues. ***HOWEVER, RESPONSIBILITY FOR PAYMENT FOR YOUR MEDICAL CARE IS YOURS - NOT THAT OF ANY INSURANCE COMPANY OR ZWEIBACH WOMEN'S HEALTH.***

In addition to the above, patients are responsible to pay their co-payment or deductible at the time services are rendered.

In the event you are a member of a **Managed Care Plan**, coverage must be confirmed prior to time of service. It is ***your*** **responsibility to obtain any referral needed from your primary care physician,** prior to receiving medical services rendered.

Should you have any questions about our billing and payment polices, please contact our billing department.

____

Patient Name (print)

__________________________________ __________________________________

Patient/Legal Guardian Signature Date Witness Signature Date

____

Print Name and Relationship to Patient (if other than Patient)

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Please fill out this form *completely*. We will be unable to file your insurance without all this information.

Patient ____ **Date**____________
Last Name First Name Middle Initial

Address ____
Street City/State Zip Code

Home Phone _______________ Cell Phone ________________ Work Phone_______________

O.K. to leave a voice message on above telephone numbers? (Yes) _____ (No) ____

Date of Birth ______________ Age_____ SS# _______________ Marital Status _________

Patient Employer _______________________ **Insured Employer** ___________________

Primary Care Physician: ____________________________ Telephone: _____________

Patient email_________________________@_______________________________

Primary Insurance Company ____________________________ HMO ( ) PPO ( ) Other ( )

Address _________________________________ Phone Number _____________________

Policy Number ______________________________ Group Number __________________

Policy Holder: Self ( ) Spouse ( ) Parent ( ) **If policy holder is spouse or parent we need the following:**

Name ______________________ SS# _______________ Date of Birth ________________

Secondary Insurance Company __________________________ HMO ( ) PPO ( ) Other ( )

Address _________________________________ Phone Number _____________________

Policy Number ______________________________ Group Number __________________

Policy Holder: Self ( ) Spouse ( ) Parent ( ) **If policy holder is spouse or parent we need the following:**

Name ______________________ SS# _______________ Date of Birth ________________

Emergency Contact ____
Name Relationship Phone Number

How did you hear about us? ____

I give my permission for ZWEIBACH WOMEN'S HEALTH to file insurance claims and receive payment on my behalf. I also understand that I am fully and directly responsible for the payment of all medical bills for services rendered to me.

I give ZWEIBACH WOMEN'S HEALTH permission to share my medical files with necessary personnel in order to provide medical care and to file insurance claims on my behalf.

_______________________________________ _________________________
Signature **Date**

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SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our **Notice of Privacy Practices**. Our full-length Notice is available at the front desk.

Effective Date: April 1, 2003

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As your physicians, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information?
Here are a few examples (for more detail please request a full-length Notice)

- For medical treatment.
- To obtain payment for our services.
- In emergency situations.
- For appointment and patient recall reminders.
- To run our Practice more efficiently and to ensure all our patients receive quality care.
- For research.
- To avert a serious threat to health or safety.
- For organ and tissue donation.
- For workers' compensation.
- In response to certain requests arising out of lawsuits or other disputes.

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. **You will not be penalized** for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- To request confidential communications
- The right to an accounting of disclosures
- The right to inspect and copy
- The right to amend
- To request restrictions
- A paper copy of this notice

Please read and sign the attached two forms:

1. Patient Acknowledgement Form (States that you received and agree to this information.)
2. Authorization for Use of Health Information (States who can receive information.)

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PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (EIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

____
Patient Name (print)

____
Patient / Legal Guardian Signature Date

____
Print Name and Relationship to Patient (if other than patient)

____
Witness Signature Date

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AUTHORIZATION FOR USE OF HEALTH INFORMATION

Name ____ DOB: _________________

I authorize the use and disclosure of health information about me as described below:
Please be advised that any one not listed will not be provided medical or finanical information.

A. Person(s) or Organizations(s) who **may** receive information (relatives, friends, doctors, etc.):
Please provide names and relationship:

____

____

B. Description of information that **may** be used or disclosed (including date(s)):

____

____

C. Restrictions on use and disclosure of my information:

____

____

____
Patient Name (print)

____
Patient / Legal Guardian Signature Date

____
Print Name and Relationship to Patient (if other than patient)

____
Witness Signature Date

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RELEASE OF MEDICAL RECORDS

To:

Physician/Facility Name:

Address:

I hereby request that my Medical Records be released to:

Zweibach Women's Health 815 S. Parsons Ave. Brandon, FL 33511	Phone: (813) 571-2777 Fax: (813) 571-2888

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PLEASE SEND:

_______________ All Medical Information and Reports
_______________ Prenatal Records
_______________ Operative Report(s)
_______________ Lab Results (including HIV, hepatitis, and all STD results)
_______________ X-Ray/Ultrasound Reports

Purpose of Medical Information Being Sought:

____
____
____
____

Print Name:

Social Security Number:

DOB:

Signature of Patient or Legal Guardian:

Print Name and Relationship (if other than Patient)

Date: