CAPITAL WOMEN'S CARE, LLC.

Please update the information below, sign the form, and return the form to the front desk. Thank you.

Patient Information

Today's Date:	Patient Medical Record Number	Referring Physician	Appointment Info

Name	Marital Status	Gender	Date of Birth	Social Security #

Address	Apartment #	City State Zip
Home	Cellular	Ext

Guarantor/Financially Responsible Party

Guarantor Name	Date of Birth	Social Security Number	Home Phone

Address	City State Zip	Day Phone
Employer	Employer Address	Occupation

Primary Insurance Information

Have you applied or intend to apply for Medical Assistance? (Circle your answer) Yes No Not Sure

Insurance Company	ID	Group
Address	City State Zip «Patient Primary City, State Zip»	Phone
Policy Holder Name	Policy Holder Date of Birth	Policy Holder Social Security
Policy Holder Employer	Patient Relation to Policy Holder	Insurance Effective Date

Secondary Insurance Information

Please note, insurance companies require you to notify them of other insurance. They may not pay the claim for this visit if the information is not in their system.

Insurance Company	ID	Group
Address	City State Zip	Phone
Policy Holder Name	Policy Holder Date of Birth	Policy Holder Social Security
Policy Holder Employer	Patient Relation to Policy Holder	Insurance Effective Date

Personal Representative Authorized To Access Protected Health Information

Name	Phone	Relationship to Patient

1. Financial Responsibility:

I certify that the information I have provided regarding my insurance coverage is correct and I authorize Capital Women's Care to verify insurance coverage and benefits allowed in accordance with my insurance plan's coverage.

I authorize that the payments be made directly to Capital Women's Care for all medical insurance benefits which are payable under the terms of my insurance policy for services provided. I agree to pay any copayment, coinsurance, or deductible as required by my insurance for the terms and regulations of my insurance plan.

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at 25% of the debt, and all costs and expenses including reasonable attorneys' fees, we incur in such collection efforts

Capital Women's Care may impose a no-show fee of $35.00 for appointments not cancelled 24-hours in advance.

2. Payment in full at time of service:
I understand that if Capital Women's Care does not participate with my insurance or I do not have insurance, payment is due in full at the time of service.

3. Release of Medical Information for Billing:

I hereby authorize Capital Women's Care to submit a claim and a copy of medical records related to such services, to my insurance company, health and welfare fund, Medical or Medicaid for medical services provided to me or my dependent. I also authorize Capital Women's Care to provide a copy of this release and a copy of medical records related to such services if requested by the payor. Further, I authorize Capital Women's Care to release medical information to my consulting or primary physicaian to assist with continuity of care. This release will expire one year from the date my signature below, unless I cancel this release in writing prior to that date.

4. Receipt of Privacy Notice:

I have been given the opportunity to review the Capital Women's Care Notice of Privacy Practices which provides a detailed description of how my Protected Health information (PHI) is used and disclosed.

5. Non Covered Services:
I agree to pay for medical services provided to me or my dependant which are not covered by the benefits in my insurance plan.

I AGREE TO THE ABOVE STATED CONSENT

Signature of Patient or Legal Guardian: **Date:**

CAPITAL WOMEN'S CARE, LLC.

Patient Information			
Name	Patient Medical Record Number	Today's Date:	Appointment Info

How did you learn about our Practice? (Circle all that apply)
Patient Referral Other Referral Website/Internet Ad//Radio/TV Other _____

Patient Ethnicity, Race and Religion and Gender Details (Please circle your response) - For Medical Decision Making Purposes Only

Ethnicity: Hispanic/Latino or Not Hispanic/Latino Will Discuss with Provider Current System Selection:

Race: Asian, Black or African American, White, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander Hispanic or Latino, Indian, Multi Racial Will Discuss with Provider Current System Selection:

Religion: Will discuss with Provider Current System Selection:

Gender Identity: Choose not to Disclose Female Female-to-Male Genderqueer Male Male-to-Female Will discuss with Provider
Current System Selection:

Sexual Orientation: Choose not to Disclose BiSexual Lesbian, Gay, Homosexual Straight or Heterosexual
Will discuss with Provider Current System Selection:

Preferred Pronoun: Decline to Answer He, Him, His Other She, Her, Hers They, Them, Theirs Ze, Hir
Will discuss with Provider Current System Selection:

Patient Allergies (Please include your reaction to each Allergy)	
Allergen	Reaction

Patient Medications (Please include dosage for each medication)	
Medication	Dosage

Patient Preferred Pharmacy	
Pharmacy Name	Pharmacy Phone
Street Address	City State Zip

Patient Communication

Capital Women's Care physicians are dedicated to helping our patients live healthy lifestyles. Your physician would like the opportunity to communicate with you via patient portal, email, and telephone about preventive health services such as well woman exams or other health promotion information. Also, there may be other messages we would like to send our patients, such as the announcement of new physicians or contract changes with insurance companies.

Patient Portal: The portal is the preferred communication method for all adults 18 years or older. This method requires an active email address and enrollment in the portal.

Email: Capital Women's Care makes this commitment to our patients about the collection of email information.

1. They will be for Capital Women's Care use only. They will not be sold to any other entity.
2. The patient's privacy will be protected. The email address will not be used to communicate any personal health information or in any manner inconsistent with the Health Insurance Portability and Accountability Act (HIPAA)
3. Emails to our patients will be one way communications and, therefore, will not allow for conversations between the patient and physician/staff.

Telephone: As a service to our clients, we provide a courtesy appointment reminder and possibly other important calls that may be placed using a pre-recorded message. By providing your cell phone number, you consent to receiving such calls at this number.

All health related questions should continue to be addressed to the appropriate Capital Women's Care staff. Additional comments and questions on our privacy policy as it relates to electronic communications, should be directed to the Capital Women's Care Compliance Officer at privacy@cwcare.net or 301-340-8339, ext 201

Patient Name: _____ Email Address:_____

Patient Signature: _____ Date: _____