ALLIANCE WOMEN'S HEALTHCARE

PATIENT DEMOGRAPHICS:

NAME: _____ **MAIDEN/FORMER NAME:** _____

TODAY'S DATE: _____

SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: _____ HOME PHONE: _____

DRIVER'S LICENSE NUMBER: _____ STATE: _____

EMPLOYER: _____ WORK PHONE: _____

SPOUSE/PARTNER : _____ SPOUSE/PARTNER CELL: _____

PHARMACY:

PHARMACY NAME: _____ NUMBER: _____

STREET ADDRESS: _____

IF YOU ARE A MINOR (UNDER AGE 18) PLEASE PROVIDE PARENT INFORMATION:

MOTHER: _____ CELL: _____

FATHER: _____ CELL: _____

_____ INITIALS	Please use this email for my portal access: _____ I understand you will EMAIL me a notice that a statement has been generated by the portal. Please choose one: ☐ Alliance Women's Healthcare **MAY** leave voice mails regarding my treatment, results, and appointments. ☐ Alliance Women's Healthcare **MAY NOT** leave voice mails regarding my treatment, results, and appointments. Please use my _____ cell or _____ home number to leave voice mails.

INSURANCE – PRIMARY AND SECONDARY:

INSURANCE CARRIER: _____ GROUP ID: _____

POLICY NUMBER: _____ EFFECTIVE DATE: _____

CLAIMS ADDRESS ON BACK OF CARD: _____

CITY: _____ STATE: _____ ZIP: _____

PLAN PHONE NUMBER: _____

IF YOU ARE NOT THE POLICY HOLDER, PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THE POLICY HOLDER:

NAME: _____ DATE OF BIRTH: _____

SSN OF POLICY HOLDER: _____ EMPLOYER: _____

IF YOU HAVE SECONDARY INSURANCE:

INSURANCE CARRIER: _____ GROUP ID: _____

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POLICY NUMBER: _____ EFFECTIVE DATE: _____

CLAIMS ADDRESS ON BACK OF CARD: _____

CITY: _____ STATE: _____ ZIP: _____

PLAN PHONE NUMBER: _____

IF YOU ARE NOT THE POLICY HOLDER, PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THE POLICY HOLDER:

NAME: _____ DATE OF BIRTH: _____

SSN OF POLICY HOLDER: _____ EMPLOYER: _____

CONSENT TO MEDICAL CARE:

_____ INITIALS	I request treatment by Jonathan C Snead MD, PA d/b/a Alliance Women's Healthcare and it's agents and employees (hereinafter collectively "AWH"). I consent to the procedures which may be performed during my course of treatment, including emergency treatment or services that may include, but are not limited to, laboratory services, x-ray examination, diagnostic procedures, surgical treatment or procedures or services rendered to me as ordered by my physician or other healthcare professionals at AWH. I voluntarily consent to treatment, realizing that no guarantees have been given to me by AWH regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue treatment at any time. However, I understand that doing so may hinder my treatment and/or medical outcome. I understand I may have HIV testing performed and consent to the test.

DISCLOSURE OF INFORMATION:

_____ INITIALS

I agree that all records concerning my treatment shall remain the property of AWH. I understand that medical records and billing information generated or maintained by AWH are accessible to AWH personnel and medical staff. Personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in my continuum of care. AWH is authorized to disclose all or part of my medical record to any insurance company, third party payors, worker's compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of my account, unless AWH has received notice by me and services have been paid in cash in full as further described in AWH's Notice of Privacy Practices. AWH is authorized to disclose all or any portion of my medical record as set forth in AWH's Notice of Privacy Practices, unless I object in writing, and may do so electronically.

Primary Care or Specialist Disclosure

I have a PCP or specialist with whom AWH may disclose, if necessary, my medical records for their use. **Said disclosure may include HIV, STI, or genetic testing results.**

My PCP or specialist is: _____

Their fax number is: _____

Family Member Disclosure and Emergency Contact

I authorize AWH to disclose my medical records and protected health information (PHI) to the following person(s):

Name: _____ Relationship: _____

Phone Number: _____ May we contact them in an emergency? _____

Name: _____ Relationship: _____

Phone Number: _____ May we contact them in an emergency? _____

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	Name: _____Relationship:_____ Phone Number: _____May we contact them in an emergency? _____ **PREGNANT PATIENTS ONLY:** My initials to the left indicate my consent to send my records, including STI and HIV testing results, to Texas Health Resources Hospital at Alliance ("THR"). If during the course of my pregnancy it becomes necessary to refer me to a high risk physician or other physician for continued treatment, my initials to the left indicate I consent to have my records, which may include STI and HIV testing results, sent for my treatment and continuation of care. *Please note: Read the Notice of Privacy Practices to fully understand the use and disclosure of your medical information.*
AUTHORIZATION AND ACKNOWLEDGEMENT TO DISCLOSE HIV AND STD INFORMATION	
_____ INITIALS	I specifically authorize Jonathan C. Snead, M.D., P.A. d/b/a Alliance Women's Healthcare "Alliance Women's Healthcare" or its designated employee(s) and agents to disclose my Protected Health Information, including HIV test results and HIV related information and other information related to sexually transmitted diseases, to any healthcare provider involved in my treatment or upon a transfer of records from AWH to another healthcare provider for the purpose of treatment. I understand that Section 181.103 of the Texas Health and Safety Code permits AWH to release HIV test results, without my consent, for various purposes including but not limited to the physician or other person authorized by law who ordered the test or a physician, nurse, or other health care personnel who has a legitimate need to know the test result to provide for their protection and my health and welfare. Said disclosure may be in electronic form.
AUTHORIZATION AND ACKNOWLEDGEMENT TO DISCLOSE GENETIC INFORMATION	
_____ INITIALS	I understand I may have genetic testing during my care. In the event I do, I authorize the disclosure of these results to any healthcare provider involved in my treatment (my PCP or a physician or specialist I am referred to) or upon a transfer of records to another healthcare provider. I am consenting to disclose the results of any genetic testing performed under the direction of Jonathan C. Snead MD PA d/b/a Alliance Women's Healthcare or its designated employee(s) and agents. I specifically authorize AWH to disclose the genetic tests indicated by a check below and related information to healthcare providers involved in my treatment for the purpose of treatment. ☐ Myriad to the following provider: _____ ☐ Q Natal to the following provider: _____ ☐ Other: _____ to the following provider: _____
LEGAL ASSIGNMENT AND BENEFITS OF AUTHORIZED REPRESENTATIVE	
_____ INITIALS	I understand and agree that I am financially responsible for charges incurred by me for services rendered by AWH and, to the extent that I have insurance and/or employee health care benefits coverage I hereby assign and convey directly to AWH, as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from AWH, regardless of AWH's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges incurred by me regardless of any applicable insurance or benefit payments. I authorize AWH to release all medical information necessary to process my claims under HIPAA. I authorize any plan administrator or fiduciary, insurer and my attorney to release to AWH any and all plan documents, insurance policy and/or settlement information upon written request from AWH in order to claim such medical benefits, reimbursement or any applicable remedies to which I am entitled. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

	I convey to AWH, to the full extent permissible under the law, including but not limited to, ERISA §502(a)(I)(B) and §502(a)(3), all rights and benefits I may have under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, appropriate equitable relief, surcharge remedy, or other right with respect to any and all medical expenses incurred as a result of the medical services I received from AWH, and to the full extent permissible under the law to claim or file a lien to such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to: (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice or document to pursue appeal proceedings; and (5) taking any administrative and/or judicial actions by such provider(s) to pursue such claim or right against any liable party or employee group health plan(s), including, if necessary, AWH filing a lawsuit against any such liable party or employee group health plan in my name with derivative standing but at AWH expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.
UNBORN CHILD COVERAGE:	
_____ INITIALS	If pregnant, the above consent for treatment, releases, assignments and guarantor agreement apply to my newborn child during the period of treatment.
INSURANCE PRECERTIFICATION:	
_____ INITIALS	I understand that precertification for my insurance is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:	
_____ INITIALS	A description of how medical information will be used and disclosed is summarized on the Notice of Privacy Practices. A complete copy of the Notice of Privacy Practice is included on the back of these intake forms. By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have questions or complaints, I may contact the Privacy Officer at 10600 North Riverside Drive, Suite 100, Fort Worth TX 76244, (817) 741-9663. I also understand there is a copy of the Notice of Privacy Practice on the website www.alliancewomenshealthcare.com.
ACKNOWLEDGEMENT TO RECEIVE PAST MEDICATION HISTORY:	
_____ INITIALS	I authorize Jonathan C Snead MD, PA d/b/a Alliance Women's Healthcare's agents and employees to electronically obtain my current and past medication history. This may include a history of HIV or psychiatric medications.
FINANCIAL AGREEMENT ACKNOWLEDGEMENT	
_____ INITIALS	I have read the Financial Agreement and signed it. I understand this is listed on the AWH website, www.alliancewomenshealthcare.com, and a paper copy is available upon request.
PATIENT PORTAL	
_____ INITIALS	I understand AWH uses an online patient portal. I understand I may access this at any time through the website, www.alliancewomenshealthcare.com, to see my current information, may update my demographic information, insurance information, and may make payment through use of the portal. Please call our office if you have a problem with the site.

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PERSONAL DEMOGRAPHIC INFORMATION INCLUDING CURRENT INSURANCE INFORMATION:	
_____ INITIALS	I understand I must contact AWH when I have a change in insurance during my care. Failure to do so may cause claims to be denied for non-coverage/failure to have coverage/failure to timely file with the proper insurance carrier. In those instances, I understand I may be held responsible for charges that were not covered or denied for any reason. I understand I must contact AWH to update my address and contact information. I understand I must contact AWH if I have any changes to this paperwork – including my disclosure authorization and emergency contact information (said changes must be in writing and received by AWH to be effective per our Notice of Privacy Practices).

I, the undersigned, as the patient, parent, guardian, spouse, guarantor, or agent of the patient, hereby certify I have read, and fully and completely understand this Intake Form and freely and voluntarily agree to be bound by its terms.

SIGNATURE: _____ DATE: _____

Printed Patient Name: _____

If signed by someone other than the Patient, indicate your name:

Printed Name:_____
Relationship to Patient: _____

NOTE: If you are signing for a Minor, please make sure the contact information is for the PATIENT and not yourself. Thank you.