

NEW PATIENT INFORMATION FORM

PATIENT INFORMATION

LAST NAME	FIRST NAME	PREFERRED NAME	MIDDLE INITIAL
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DATE OF BIRTH	SS#	GENDER	RACE/ETHNICITY
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MAILING ADDRESS	CITY/STATE	ZIP CODE
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CELL PHONE	HOME PHONE	WORK PHONE
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EMAIL ADDRESS	EMPLOYER	PREFERRED LANGUAGE
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EMERGENCY CONTACT

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT
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PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY	SUBSCRIBER'S FULL NAME	SUBSCRIBER'S EMPLOYER
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GROUP NUMBER	SUBSCRIBER NUMBER	INSURED DATE OF BIRTH
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SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY	SUBSCRIBER'S FULL NAME	SUBSCRIBER'S EMPLOYER
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GROUP NUMBER	SUBSCRIBER NUMBER	SUBSCRIBER DATE OF BIRTH
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PREFERRED PHARMACY

PHARMACY NAME	LOCATION/ADDRESS	PHONE NUMBER
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HOW DID YOU HEAR ABOUT VIDA? _____

Vida Gynecology
330 C Pelham Road, Suite A Greenville, SC 29615
864-720-1299 www.vidagyn.com

PATIENT PRIVACY FORM

PATIENT'S NAME

DATE OF BIRTH

SHARING INFORMATION

Please list who has permission to receive information from Vida Gynecology other than the patient.

Name of person that has permission to receive the above patient information Relationship to patient

Name of person that has permission to receive the above patient information Relationship to patient

COMMUNICATION

I authorize Vida Gynecology to leave a message regarding: (Check ONLY ONE)

- All information including appointments, general information, updates, billing, etc.
- Appointment information ONLY On my voicemail on the: Check ALL that apply.
- Cell Phone Number Home Phone Number

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time by sending notification to Vida Gynecology 330 C Pelham Rd., Suite A Greenville, SC 29615. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may result in redisclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for their own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or copy the protected health information disclosed as described in this document. I can do this by written notification to: Vida Gynecology 330 C Pelham Rd, Suite A Greenville, SC 29615. I understand that I have the right to refuse to sign this authorization

I have read and received a copy of the Notice of Privacy Practices for Vida Gynecology.

Signature

Date

Relationship if not patient

RESPONSIBLE PARTY ACKNOWLEDGEMENT FORM

RESPONSIBLE PARTY

The Responsible Party is the person who is FINANCIALLY responsible for the patient's account(s) and who will receive all account statements to their address. By signing, I understand that I am the responsible party and will adhere to the requirements outlined in the policies provided to me for the following patient(s) as well as future patients registered in my name at Vida Gynecology. If you are eighteen or older, you are your own responsible party.

NAME OF RESPONSIBLE PARTY (Please Print)

RELATION TO PATIENT(S)

PATIENT(S) COVERED BY RESPONSIBLE PARTY

Patient's Last Name

First Name

Date of Birth

Patient's Last Name

First Name

Date of Birth

Patient's Last Name

First Name

Date of Birth

WAIVER OF LIABILITY

I understand that the treatment/service from the providers and physicians at Vida Gynecology for the patient(s) listed above may not be a covered treatment/service or may not be covered at 100%. I agree to be personally and fully responsible for any balance due.

PAYMENT POLICY

Vida Gynecology is committed to providing the best treatment for our patients. Our pricing structures are representative of the usual and customary charges for our area. Thank you for adhering to our payment policy. Signing below indicates that you are the responsible party which means you are financially responsible for this patient and have read and understand the payment policy and agree to abide by its guidelines.

RESPONSIBLE PARTY ACKNOWLEDGEMENT

I understand that I am the responsible party for the patient(s) listed above and any future patient(s) registered in my name at Vida Gynecology, and I agree to the terms of the Waiver of Liability and Payment Policy. I have been given a copy for review and I am aware of the availability of these documents in the office of Vida Gynecology as well as online at www.vidagyn.com.

Signature of Responsible Party

Date

PRIVACY NOTICE (HIPAA POLICY STATEMENT)

Vida Gynecology's Privacy Notice to Patients

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED BY VIDA GYNECOLOGY AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Effective Date: July 1,2016

Under the HIPAA Privacy regulations, Vida Gynecology and all similar health care providers are required by federal law to maintain privacy of your protected health information (PHI) and will abide by the terms in the Privacy Notice. Please be advised that Vida Gynecology may use your PHI in rendering treatment. For example, we are permitted to use your PHI in providing you with medical care/treatment when you visit our office or when we treat you in a hospital or nursing facility. Under federal law, we may disclose your PHI to you, or we can disclose your PHI to third parties for treatment. For example, if we refer you to a specialist, we will forward your medical information to such specialists. We can disclose your PHI for payment purposes. For example, we will disclose your PHI to your insurance provider, your employer, Medicare, Medicaid, or other parties responsible for providing you with health insurance coverage in order for Vida Gynecology to be reimbursed for our services rendered to you. We will also use or disclose your PHI for health care operations. For example, we may use your PHI when we engage in quality assurance and medical chart reviews, which are part of our health care operations. We may also disclose your PHI, when required by the Secretary of the US Department of Health & Human Services. Unless disclosure is required under federal/state law, or certain other exceptions, including law enforcement, we are prohibited from disclosing your PHI without your authorization. Our practice may use or disclose your PHI in accordance with the specific requirements of the HIPAA rules without Vida Gynecology needing to obtain your authorization if the information is:

- 1.required by law
- 2.required for public health purposes
- 3.required disclosures about victims of abuse, neglect or domestic violence
- 4.required by health oversight agency for oversight activities authorized by law
- 5.required in the course of any judicial or administrative proceeding
- 6.required for a law enforcement purpose to a law enforcement official
- 7.required by a coroner or medical examiner
- 8.required by an organ procurement organization for research, and
- 9.necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Additionally, if you are a member of the armed forces, Vida Gynecology is permitted to disclose your PHI without consent if deemed necessary by appropriate military command authorities to ensure an appropriate military mission. We may also contact you via mail or phone to remind you of appointments with our office or to discuss treatment alternatives. If, for any reason, you do not wish to be contacted via mail or phone, our office personnel will note your request in your chart. In the event our practice wishes to disclose your PHI to another entity besides those referenced above, we are required to obtain your authorization. We would seek to obtain your authorization if Vida Gynecology decided to release your PHI for reasons other than treatment, payment, or for our practice's operations. For example, if we desired to participate in outside research or a drug study, we would need your written authorization prior to being permitted to release your PHI to such outside research facility or drug manufacturer. If you provide us with an authorization, you have the ability to revoke such authorization at any time by sending Vida Gynecology a written revocation. However, if we have already released such information pursuant to your prior authorization, the revocation will be effective for all future disclosures. Please be further advised that you have the ability to access, obtain a copy, inspect, and request amendment to your medical information that we maintain. Additionally, if you desire, Vida Gynecology can provide you with an accounting of all disclosures for treatment, payment, or healthcare operations pursuant to authorization. If you have a dispute with our practice regarding the use of your PHI or a disclosure by Vida Gynecology and believe that your primary rights have been violated, please contact Vida Gynecology to file a complaint or you may contact the Secretary of Health and Human Services. We welcome feedback from our patients through our website "contact us form" or via email at info@vidagyn.com. Please understand that Vida Gynecology will not retaliate against you in any way for filing a complaint. Lastly, please be advised that you have the right to designate a personal representative or request restrictions on certain uses and disclosures of your PHI to carry out treatment, payment or healthcare operations or disclosures by Vida Gynecology of your PHI to a family member, relative, or a close personal friend. However, we are not required by federal law to agree to your requested designation or restriction. If you request a copy of your PHI, you also have the ability to request that we send it to an alternative location (different address) and by alternative means.

Additionally, if you have received this notice in an electronic form and you would like a paper copy, please contact Vida

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Gynecology's Privacy Contact. Vida Gynecology reserves the right to amend this notice as revised. Notices will be posted on our website (www.vidagyn.com) and in our offices and provided to you upon your request. Thank you and if you have any questions, please contact Vida Gynecology at 864-720-1299.

PAYMENT POLICY

PROOF OF INSURANCE: All patients must complete their patient information forms before seeing the provider. We must obtain a copy of your current, valid insurance card for proof of insurance. If you fail to provide us with the correct insurance information at the time of service, you may be responsible for the balance of your claim.

COPAYMENTS AND BALANCES DUE: All copayments and balance dues must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

CLAIM SUBMISSION: We will submit your claims to your insurance provider and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

MONTHLY BILLING STATEMENT: After your insurance company pays Vida Gynecology, you will receive a monthly billing statement, which indicates your balance due and/or deductible due. These amounts are payable to Vida Gynecology. The balance due is payable in full within 10 days of receipt of the monthly billing statement. If you have questions about your account, please call 864-720-1299.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan, we do business with or do not have insurance, payment in full is expected at each visit. If you are insured by a plan, we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Vida Gynecology will file to your primary and secondary insurance.

COVERAGE CHANGE: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If we cannot verify active coverage, the balance will automatically be billed to you.

NON-PAYMENT: Partial payments will not be accepted unless otherwise negotiated with the billing department. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this practice. You will be responsible for any collection or legal cost associated with collecting your account. If this were to occur, you will be notified that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

MISSED APPOINTMENTS: In order to achieve the best appointment availability for our patients, we have a policy for missed appointments. There will be a \$25 charge added to the account for each missed appointment, and a \$50 fee for a missed appointment by a new patient. Three missed appointments within a 12-month period will result in eligibility for discharge from the practice for the patient. We understand the potential for unforeseen circumstances that may cause a late arrival or missed appointment. If this happens, please call us as soon as possible so we can change your appointment status accordingly and make it available for another patient.

CANCELLATIONS: Our policy is to charge \$25 for previously scheduled appointments that are canceled less than 24 hours prior to their scheduled time/date. These charges will be your responsibility and billed directly to you, and not your insurance company. Please help us serve you better by keeping your regularly scheduled appointments.

NON-COVERED SERVICES: Please be aware that some and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. Since all insurance plans are different, please contact your insurance company or HR department for detailed information about what is covered or not covered including annual physical maximums, immunizations, etc. You will be billed and responsible for all non-covered services. We charge a \$15 fee in order to fill out forms that are brought into the office outside of an appointment.

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FORMS OF PAYMENT: Vida Gynecology accepts payments by cash, check, money orders, Visa, MasterCard, American Express, Discover, and debit cards bearing these logos. Payment is expected at the time of service.

BCBS STATE ANNUAL: If you are a patient that has BCBS State, please be aware that your preventive visits may not be covered. Please contact your insurance to confirm your benefits prior to your appointment. Anything that is not covered by your insurance company will be your responsibility. Please initial here. _____

SURGERY: For all surgeries, our office will confirm your insurance coverage in advance. We will contact you with an estimated cost for the surgery based on how much your insurance has agreed they will cover and how much your insurance company states is your responsibility. Payment for surgeries will be collected in full, prior to your appointment. Please contact your insurance company with any concerns regarding your coverage. Please initial here. _____