



## Welcome To Our Practice

We're so pleased that you've chosen WomanCare. We know that you have many alternatives when it comes to your health and wellness, and we are honored that you've selected us.

WomanCare exists to provide comprehensive, compassionate health care to women of all ages. Our goal is to provide you with the best care available today, in the most comfortable setting, using the most advanced technology.

In order to help you become better acquainted with our practice, we've outlined some of the basics every patient needs to know regarding insurance and billing. We want to be sure you're comfortable with every facet of our practice, including the financial aspects, and we encourage you to let us know if you have any questions or concerns. We know that dealing with insurance regulations and the constant changes in coverage can be frustrating, and our goal is to keep things as clear and simple as possible for you.

Please bring to your appointment:

1. Please complete the enclosed forms and bring them with you the day of your appointment. Completion of these forms prior to your visit will save you time and allow you to see the doctor more quickly on the day of your appointment.
2. Your co-pay (if you have one) will need to be paid the day of your appointment, before being seen.
3. Any office fees that apply to your deductible will need to be paid the day of your appointment as well.
4. If your insurance requires a referral, please obtain this prior to your visit.

If we do not participate with your insurance, payment in full will be necessary on the day of your appointment. As a courtesy to you, we will be glad to file with your insurance for reimbursement.

If you have no insurance coverage, we ask that you pay in full at the time of your appointment. For your convenience, WomanCare accepts both Visa® and MasterCard®.

If you have any questions at all regarding billing or insurance, please feel free to call us at 280-2134 or 282-6114 and ask for extension 17.

If you need to cancel or reschedule your appointment, please call and give us 24 hours notice, so that we may see other patients who need care.

Again, we're excited that you have chosen WomanCare. We are committed to providing you with warm and professional care, and we look forward to serving you for many years to come.

Sincerely,

Christopher S. Grady, MD  
Ronald L. Wright, MD  
Sylvia L. Stell, MD  
Elizabeth Ann Bary, CNM  
Alison Reid, RN, CNM  
Damara Jenkins, RN, CNM



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Alison Reid, RN, CNM

Sylvia L. Stell, MD  
Damara Jenkins, RN, CNM

1. Name of Patient: \_\_\_\_\_  
Last First Middle

2. Home Address: \_\_\_\_\_  
Street  
City State Zip

3. Please check one: Married Single Widowed Divorced

4. Home Telephone: (Area Code\_\_\_\_) \_\_\_\_\_ Cell Phone: \_\_\_\_\_

5. Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

6. Employment if Applicable: \_\_\_\_\_ Business Telephone: \_\_\_\_\_

7. Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**\*PHONE NUMBER OF EMERGENCY CONTACT MUST BE DIFFERENT THAN PATIENTS!**

8. Family Medical Doctor: \_\_\_\_\_ Referred By: \_\_\_\_\_

**Spouse Information**

9. Name of Spouse: \_\_\_\_\_  
Last First Middle

10. Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

11. Employment: \_\_\_\_\_ Business Telephone: \_\_\_\_\_

**Insurance Information**

12. Primary Insurance Co: \_\_\_\_\_  
ID# \_\_\_\_\_ Group # \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Relationship to Subscriber: \_\_\_\_\_  
Subscribers Date of Birth (if other than patient) \_\_\_\_\_

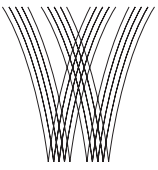
13. Secondary Insurance Co: \_\_\_\_\_  
ID# \_\_\_\_\_ Group # \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Relationship to Subscriber: \_\_\_\_\_  
Subscribers Date of Birth (if other than patient) \_\_\_\_\_

**Please Read**

I hereby authorize the office of WomanCare to release any information to my insurance company or another physician, including diagnosis and treatment, or examination rendered to me while under their care. If WomanCare files my insurance claims for me, I authorize and request my insurance company to pay directly to WomanCare any benefits due me in pending claims for medical treatment and services. I understand that I am responsible for payment of my account regardless of the status of an insurance claim and agree to pay for services rendered to me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

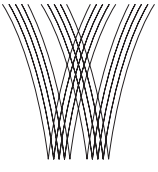


WomanCare

WOMANCARE, LLC  
PRIVACY POLICY

This notice is provided in accordance with HIPAA (Health Insurance Portability and Accountability Act), a government regulation established to protect the privacy of patients' health information. It describes how we may use or disclose your protected health information to carry out treatment, payment, or healthcare operations for other purposes that are permitted or required by law. It also describes how patients can gain access to such information. Please review this carefully. If you should have any questions regarding this notice, please contact our privacy officer at (812) 282-6114 Ext. 20

1. We may use and disclose protected health information upon your written consent or for purposes of treatment, payment, or healthcare operations.
2. Other uses of your healthcare information will be made only with your written authorization, for which you may revoke.
3. We may use and disclose your health information to others involved in your healthcare (unless you stipulate otherwise). Examples are other healthcare agencies, physicians, a family member who has written authorization to receive information, in emergency situations or situations where there are communication barriers.
4. Other permitted uses and disclosures without your consent may be required by law; for public health activities, communicable disease notifications, suspected abuse or neglect, Food and Drug Administration for medical problems, legal proceedings, and law enforcement. Information may be disclosed to coroners, funeral directors, organ donation programs, for research in criminal activities, military activity and matters of national security, for worker's compensation, and for inmates required by law.
5. You have a right to inspect and copy your health information.
6. You have a right to request a restriction of your protected health information.
7. You have a right to request and receive confidential communications from us by alternative means or an alternative location.
8. You have a right to request that your physician amend your protected health information.
9. You have a right to receive notification of certain disclosures we have made, if any, of your protected information.
10. You have a right to obtain a copy of this notice or a more detailed policy from us upon request.
11. You have the right to contact the Secretary of Health and Human Services if you believe that our office has violated the rights or your privacy.



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ACKNOWLEDGMENT OF RECEIPT OF THE HIPAA PRIVACY NOTICE

I have received the Practice's HIPAA Notice and understand that my protected health information may be used by the practice as described in the notice.

Please list below the individuals, if any, and their relationship to you that you give permission to have access to your protected health information.

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Patient Name (Print): \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_