OLATHE WOMEN'S CENTER

BRUCE B. SNIDER, M.D.   LUINA ESTRADA, M.D.   SARAH M. MAIER, WHNP

PATIENT INFORMATION FORM

HAVE YOU VERIFIED THAT WE ARE PROVIDERS FOR YOUR INSURANCE: YES / NO

Legal Name ______________________ Preferred Name ______________________ DOB __________

Phone (H) ______________________ (C) ______________________ (W) ______________________

Physical Address ______________________ Apt # _____ City ______________ State______ Zip__________

Mailing Address ______________________ Apt # _____ City ______________ State ______ Zip __________

E-mail ____

Drug Allergies ____ Marital Status M S D W

Ethnicity (Please circle) Non-Hispanic Hispanic

Employer ______________________________ Occupation ______________________________

Pharmacy Name & Address ____

Spouse's Name ______________________________ DOB ____________ Phone # ______________

Spouse's Employer ______________________________ Occupation ______________________________

Nearest Friend or Relative Not Living With You ______________________ Phone # ______________

Referring Doctor ______________________________ Phone # ______________________

How did you hear about us? Doctor Friend/Relative Web-site Insurance

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IF APPLICABLE

Father's Name ____ Phone # ______________________

Father's Address ____

Father's DOB __________________

Father's Employer ____ Work Phone # ______________________

Mother's Name ____ Phone # ______________________

Mother's Address ____

Mother's DOB __________________

Mother's Employer ____ Work Phone # ______________________

Please present your correct insurance card to the front desk for copying. Olathe Women's Center is not responsible for unpaid claims or laboratory charges due to incorrect insurance information presented to us. A $7.00 fee will be charged to your account for any insurance re-filing. All co-payments are due at the time of the visit.

Name of Person Financially Responsible For Charges ____
(This is either patient or parent)

Name of Insurance ______________________________ ID # ______________________________

Name of Insurance Policyholder ____

NOTICE TO PATIENTS: PLEASE READ THIS AGREEMENT BEFORE YOU SIGN IT.

You are entitled to a copy of this agreement. I understand that I am primarily responsible for all bills incurred by me as the responsible party. Should my insurance company fail to pay my claim(s) within sixty (60) days, I agree to pay the balance in full upon request from this office. Failure to do so will result in my account being charged an ANNUAL PERCENTAGE RATE (APR) of 12% compounded daily on the outstanding balance then due. To avoid these interest charges, I understand I must pay the balance within a 30 day grace period allowed by Olathe Women's Center following notification of my outstanding balance. If my account remains unpaid and Olathe Women's Center must use collection efforts of an outside agency, I fully understand that I am responsible for paying all collection costs incurred by Olathe Women's Center that can be charged to me in accordance with the law.

____ _______________________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

PATIENT HIPPA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information (PHI) to carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), obtaining payment from third party payers (e.g. my insurance company), and the day-to-day healthcare operations of your practice third party organizations (TPO).

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

PHONE CORRESPONDENCE

With this consent, Olathe Women's Center may call my home or other alternative location, which I provide and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory tests results, among others.

YES NO

MAIL CORRESPONDENCE

With this consent, Olathe Women's Center may mail to my home or other alternative location as provided by me, any items that assist the practice in carrying our TPO, such as appointment reminder cards and patient statements.

YES NO

ELECTRONIC CORRESPONDENCE

With this consent, Olathe Women's Center may e-mail me at address I provide any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Olathe Women's Center restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

YES NO

THIRD PARTY CORRESPONDENCE

With this consent, Olathe Women's Center may disclose my PHI to the following party:

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NAME OF PERSON INFORMATION TO BE RELEASED TO

____

RELATIONSHIP TO PATIENT

BY SIGNING THIS FORM, I AM CONSENTING TO ALLOW OLATHE WOMEN'S CENTER TO USE AND DISCLOSE MY PHI TO CARRY OUT TREATMENT, PAYMENT, AND DAY-TO-DAY HEALTHCARE OPERATIONS OF THE PRACTICE.

SIGNATURE ___________________________________ DATE_____________________