431 Park Avenue
Suite 300
Falls Church, VA 22046
(703) 528-6300

Healthcare For Women
OBSTETRICS and GYNECOLOGY

1875 Campus Commons Drive
Suite 110
Reston, VA 20191
(703) 437-8080

Year: _____

PATIENT INFORMATION

Account #: _____

Name First	Middle	Last	Date of Birth	Marital Status ❑ S ❑ M ❑ D ❑ W
Home Address	Apt. No	City	State	Zip Code
Phone No. Cell	Phone No. Home	Phone No. Work		Preferred Method of Contact ❑ Text ❑ Email ❑ Call
Email Address		Preferred Language		Race & Ethnicity
Employer		Employer Address		
Spouse (or Parent) Name		Spouse (or Parent) Phone No.		Emergency Contact and Phone No.
Preferred Pharmacy Name, Address, and Phone No.				Mail Order Pharmacy

NOTICE OF PRIVACY PRACTICES (HIPAA)

*** I have received and/or reviewed Healthcare for Women's Notice of Privacy Practices (HiPAA) today, I authorize this practice to call/leave messages regarding my medical appointments, test results, conditions, etc. at: ☐ Home _____ ☐ Work _____

☐ Cell _____ Patient Signature _____

*** I authorize the following individual(s) to have access to my medical appointments, test results, conditions, etc.:

1. Name: _____ Phone: _____ 2. Name: _____ Phone: _____

PRIMARY INSURANCE

Insurance Company Name	ID or Policy Number	Group/Code	Date Effective
Subscriber's Name	Relationship to Patient	Subscriber's Social Security #	Subscriber's Date of Birth

SECONDARY INSURANCE

Insurance Company Name	ID or Policy Number	Group/Code	Date Effective
Subscriber's Name	Relationship to Patient	Subscriber's Social Security #	Subscriber's Date of Birth

PATIENT AUTHORIZATION

I certify that all of the above information is true and accurate. I hereby authorize Healthcare for Women to apply for benefits on my behalf for services rendered with my Insurance company using the information I have provided. I further authorize the release of any necessary information, including medical information for any related claim, to the above named insurance company. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named Insurance company, at any time in writing.

Date _____ Signature _____

Healthcare For Women
OBSTETRICS GYNECOLOGY

Dear Patient:

PREVENTIVE VISIT and PROBLEM/SICK VISIT

Please be aware that a preventive visit/well woman exam is to address preventative care ONLY and is not to treat problems, new medical conditions, or to follow up on existing medical conditions.

If your provider evaluates and/or treats you for a problem or a new or previous medical condition at the same time of your scheduled preventive visit/well woman exam, a separate visit may be billed to your insurance company. Depending on your insurance benefits, this may result in an additional financial responsibility for the patient (copay, co-insurance, and/or deductible).

TELEHEALTH VISIT

For your convenience, Healthcare for Women is offers TELEHEALTH VISITS for our established patients. You may schedule a telehealth visit but the provider may still require an in person visit.

Obstetrical patients can be treated via Telehealth regardless of their insurance coverage for this service.

OBSTETRICAL PATIENTS

For billing purposes, your prenatal care (1st OB visit) starts at 14 weeks of gestation AFTER your pregnancy has been confirmed via ultrasound and blood work. Any visits prior to your 1st OB visit, will be billed to your insurance company and are subject to a copay or deductible.

We encourage our patients to get familiarized with their medical coverage/benefits to avoid unexpected expenses.

I acknowledge that I have read this notice; and, I understand that I am responsible for any expenses not covered by my insurance benefits.

YOUR NAME: _____

SIGNATURE: _____ DATE: _____

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FINANCIAL POLICY 2024

Thank you for choosing us as your Gynecologist/Obstetrician. We are committed to render the best health care to our patients. The following is information regarding our financial policy. We would like for you to read and sign accordingly.

INSURANCE COPAYMENTS, CO-INSURANCE, AND DEDUCTIBLES
If our physicians participate with your insurance company, we will file for insurance benefits and accept payments per our contractual agreement with the insurance company. All patients MUST provide a valid insurance card as proof of coverage and a government issued ID for the claim to be processed. If no valid insurance card or no card is provided at time of visit, you will be asked to pay upfront for the visit. You do have the choice of re-scheduling the appointment. Knowing your insurance benefits and notifying this office of any changes in your insurance coverage is your responsibility.

IF OUR OFFICE DOES NOT PARTICIPATE WITH YOUR INSURANCE COMPANY OR YOU ARE A SELF-PAY PATIENT, YOU MUST MAKE PAYMENT IN FULL AT THE TIME SERVICES ARE RENDERED-NO EXECPTIONS. For your convenience, we accept cash and debit/credit card (Visa, MasterCard, Discover, and American Express). **IF NO PAYMENT IS MADE AT TIME OF SERVICE AND A BALANCE REMAINS ON THE ACCOUNT AFTER THE SERVICE DATE A ONE TIME FEE OF $50 WILL BE POSTED TO THE ACCOUNT FOR A BALANCE FEE.**

COPAYMENTS, CO-INSURANCE, AND DEDUCTIBLES
When applicable, the patient is responsible for co-pays, deductibles, or co-insurance at the time services are rendered. This arrangement is part of your contract with your insurance company. Any questions or disputes concerning coverage or payment of benefits, is a matter between the policy holder and the insurance company. Any assistance in this matter granted by our practice is given strictly as a courtesy and implies no responsibility on our practice for the charges incurred by the patient.

PRIOR AUTHORIZATION/REFERRAL
If your insurance requires a referral/authorization for services, it is your responsibility - as the patient- to obtain the referral/authorization prior to your visit. If you do not obtain the proper referral/authorization and receive services, you will be responsible for all charges incurred.

COVERED SERVICES
It is your responsibility to know if our physicians and on-site lab participate with your insurance. Please know your plan policy in regards to all laboratory and screening/diagnostic testing. If your insurance company pays you directly, it is the patient's responsibility to forward the payment to the physician/lab/radiology immediately.

If you are being seen for an annual preventive exam and you discuss with the physician any unrelated medical condition, a separate office visit will be billed to your insurance company. Depending upon your benefits, this visit may be subject to your copay, deductible, or co insurance.

PAYMENT POLICIES
Payment of your balance for non-covered services is due within 30 days of the insurance payment or denial. If our practice does not receive benefit payments from your insurance company 60 days from the service date, the charges will be the responsibility of the patient. These are usual agreements between you and your insurance company, not this office. If your balance is 91 days or more from service date, you may incur a "balance fee" of $100.00 per account including finance charges. If your balance is 121 days old or greater from the service date, the account will be turned over to a collection agency or attorney for handling and you may be discharged from the practice. Possible actions by the collection agency or attorney may include credit reporting and legal pursuit of payment. Please understand that you may be responsible for fees/charges incurred by the services provided by the collection agency/attorney.

This office does not accept personal checks unless paying a balance due through the mail. For your convenience, we accept cash and debit/creditcard (Visa, MasterCard, Discover, and American Express). You can also pay online at www.healthcareforwomenpc.com. Returned check policy: checks that are returned by the bank for insufficient funds or stopped payments will have a fee of $75 added to the patient's account. This will also result in our inability to accept future personal checks on the account.

FEES

Co-pay not made at time of service	$10	Returned check/stop payment	$75
Self pay not paid at time of service	$50	No show/missed appointments	$50
Balance fee (remaining after 91 days)	$100	Surgery cancellation within a week of treatment	$200
Lost prescription replacement	$15	Medical records processing (based on # of pages)	
Forms/letter of disability	$35		

CERTIFICATION
I certify that the information I have reported concerning my insurance coverage is correct and that the above be honored by my current insurance carrier. I also certify that I have read the above financial policy. I understand and fully accept the terms therein.

Patient's Signature: _____ Date: _____