Takoma Park Gynecology, LLC

Carina A. Ryder, MS, CNM, NCMP
7050 Carroll Ave., Suite 201, Takoma Park, MD 20912
Phone 301-960-1155 Fax 301-960-0097

Patient Information Form

Name:_____ Date of Birth: _____ Age: _____

Address: _____ _____ _____

City: _____State: _____ Zip Code: _____

Phone #: _____Email: _____ _____

Occupation: _____ Where do you work? _____ _____

How did you find Takoma Park Gynecology, LLC? _____ _____ _____

Health Insurance Carrier:_____ _____

Group Policy Number:_____ _____

Member ID Number: _____ _____

Primary Care Provider _____

Pharmacy _____ Phone _____

Emergency Contact Name _____ Phone _____

Medical Consent

I consent to examination, diagnosis and treatment by the clinicians of Takoma Park Gynecology, LLC. Standard gynecological and general medicine diagnosis and treatment includes, but is not limited to: Pap smears, sexually transmitted infections, pregnancy testing, complete physical exams including breast, genital and pelvic exams. Takoma Park Gynecology, LLC employs ARNPs (Advanced Registered Nurse Practitioners) and CNMs (Certified Nurse Midwives), who are licensed to practice medicine, order and interpret all laboratory and diagnostic tests, and write prescriptions under Maryland laws. I consent to be examined, diagnosed, and treated as above. I understand that payment in full is due at the time of visit.

Patient Signature:_____ Date: _____

Witness: _____

AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Takoma Park Gynecology, LLC, as for your healthcare needs. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read, and agree to, prior to any evaluation and/or treatment.

1. Fees for services are due at the time of your visit, unless other arrangements have been made in advance of your appointment. We accept cash, check, credit cards (including FSA/HSA cards), e-payment and Medicare. We are out-of-network for Medicaid, Tricare, and all commercial insurances.
2. It is your responsibility, as a patient, to understand your insurance benefits, including whether or not you have out-of-network benefits, the amount of your out-of-network deductible, and whether or not you have met your out-of-network deductible.
3. It is your responsibility, as a patient, to provide current, and accurate insurance information, including any updates or changes in insurance coverage.
4. We are happy to submit your insurance claim for your visit directly to your insurance company. This process generally takes 45-60 days from the time the claim is received by the insurance company. Should the claim require corrections in coding, we will make the adjustments, and resubmit the claim on your behalf. Questions about your insurance policy and coverage are best directed to your insurance carrier, or your employer's Human Resources administrator, if applicable.
5. I hereby authorize Takoma Park Gynecology, LLC, to release to my insurer, independent laboratories, governmental agencies, or other entity financially responsible for my medical care, all information, including diagnosis, and the records of any treatment or examination rendered to me needed to substantiate payment for medical services, as well as information required for pre-certification, authorization, or referral to other providers.
6. I hereby authorize and direct payment to Takoma Park Gynecology, LLC, of my Medicare benefits on my behalf, for services furnished to me by the practice providers. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that I am financially responsible for services provided to me. I agree to pay all such charges in full.

_____

Name

_____

Signature

_____

Date of Birth

Patient HIPAA Acknowledgement and Designation Disclosure Form

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996. (HIPAA) I understand that this information explains:

- ☐ How this office will use and disclose my protected health information.
- ☐ My privacy rights with regard to my protected health information.
- ☐ This office's obligations concerning the use and disclosure of my protected health information.

I have been given the right to review and receive a copy of the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request. A copy of the *Notice of Privacy Practices* can be found online, or at our office. You may contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures.

Disclosures to Friends and/or Family

If you wish to designate a family member or other individual with whom the provider or staff may discuss your medical condition(s), provide the information below. You may revoke or modify this specific authorization, but you must do so in writing.

NAME	RELATIONSHIP	CONTACT NUMBER

Patient or Personal Representative Acknowledgment of Receipt of Notice of Privacy Practices

Signature: _____ Date: _____

Name (print): _____ Relationship to Patient: _____

FOR OFFICE USE ONLY

We made a good-faith effort to obtain an acknowledgement of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

- ☐ Patient refused to sign (date of refusal) _____.
- ☐ An emergency situation prevented us from obtaining an acknowledgment.
- ☐ Other

Attempt was made by: _____ Date: _____