

FIELDS CENTER FOR WOMEN'S HEALTH & ROBOTIC SURGERY

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Patient Information (Please Print Clearly)

Patient Legal Name: _____ Date of Birth: _____

Social Security #: _____ Race: _____ Sex: _____ Marital Status: _____

Address: _____

City: _____ ST: _____ Zip: _____

Home Number: _____ Cell Number: _____

Preferred Contact Method (please circle one) Home Cell

Pharmacy: _____ Pharmacy Phone: _____

Primary Care Physician: _____

Email Address: _____

Would you like to register for the patient portal? (please circle one) Yes No

Parent Information: (If patient is a minor)

Mother/Father/Guardian Name: _____ Date of Birth: _____

Social Security #: _____ Phone: _____

Address: (If different than child) _____

In the event that my spouse or I are unavailable, I give permission to Fields Center for Women's Health & Robotic Surgery to provide medical care and treatment to my child as they deem necessary while my child is under the supervision of:

Name: _____ Relationship to Patient: _____

By signing below, I certify all information is true and correct to the best of my knowledge

Patient Signature: _____

Date: _____

Emergency Contact:

Name: _____ Phone: _____

Relationship: _____

Guarantor Information (Primary Insured Person):

Guarantor Name: _____ Date of Birth: _____

Social Security Number: _____ Phone: _____

Address: (If different than patient) _____

Relationship to patient: _____

Employment:

Employer Name: _____ Phone: _____

Address: _____

Please Initial the Following:

_____ I hereby give permission to Fields Center for Women's Health & Robotic Surgery to provide medical care and treatment for myself as the deem necessary.

_____ I hereby authorize payment benefit directly to Fields Center for Women's Health & Robotic Surgery. I also authorize release of any medical record information for insurance purposes.

_____ Your insurance policy is a contract between you and the insurance company. It is your responsibility to know what type of coverage you have. We will bill your insurance carrier but cannot guarantee benefits or amounts covered. **You will be responsible for the balance of payment**, which is due within 30 days or as arranged with our office manager. Co-payments are due at the time of service. Adults accompanying a minor are responsible for the payment of services.

_____ I am aware the Fields Center for Women's Health & Robotic Surgery uses an electronic prescription system which allows prescriptions to be electronically sent to my pharmacy. I understand that my provider will be able to see information about medications I am already prescribed by other providers.

_____ I consent to the photographing and videotaping for medical record documentation purposes in surgery. These photos/videos are maintained and released in accordance with protected health information regulations.

HIPAA PRIVACY RULE:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information.¹ To fulfill this requirement, HHS published what are commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule. The Privacy Rule, or Standards for Privacy of Individually Identifiable Health Information, establishes national standards for the protection of certain health information. The Security Standards for the Protection of Electronic Protected Health Information (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form. The Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that organizations called “covered entities” must put in place to secure individuals’ “electronic protected health information” (e-PHI). Within HHS, the Office for Civil Rights (OCR) has responsibility for enforcing the Privacy and Security Rules with voluntary compliance activities and civil money penalties.

I give permission for providers/staff to verbally discuss medical information (including symptoms, diagnosis, medications, lab/test results, treatment plan) with:

Name: _____ Phone: _____

Relationship to Patient: _____

Name: _____ Phone: _____

Relationship to Patient: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____