Women's Health Associates
An AXIA Women's Health Care Center

# HIPAA
# Acknowledgements and Authorizations

## Print Name:_______________________________________ Date of Birth:____________

**Be advised, patients are to know their own insurances policies and benefits. This includes but is not limited to knowing lab and hospital benefits, responsibilities and affiliations, referral and prior authorization requirements.**

## I. Authorization for use or Disclosure of Health Information

### *Patient Contact Information*

**Automated Calls:** As an added convenience, we offer automated appointment reminders via a text message or an automated call for those who want to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for appointment reminders.
I understand under the telephone consumer protection act, that in order for you to contact me for services relating to my medical care, including monies I may owe, I agree that Regional Women's Health Group, LLC and/or your agents may contact me by telephone, including my cell phone, which may result in charges to me. You may also contact me by text messages, or emails providing that I have consented below. Methods of contact may include using prerecorded/ artificial voice messages and/or use of an automated dialing device, as applicable.

Address: ____________________________________________________________________________

Yes, I want to participate, my cell number is provided below.
Cell Phone Number: ________________________________
I would like my reminders to come via Text. ☐yes ☐no

No, I do not wish to participate at this time. I would prefer to be notified by:
Mail Home# ____________________ £e-mail (via the Portal – *you will need to participate, see below*.)

Pcp:_________________________ Marital Status: pSingle pMarried pWidowed p Separated p Divorced p Partner

I authorize messages with medical information to be left on voicemail/answering machine at: ______________________

### *Release of Medical History and Treatment Information*

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name: ________________________________ Relationship: ____________________ Phone:____________________

Name: ________________________________ Relationship: ____________________ Phone:____________________

*Minors & Wives PLEASE NOTE: If your PARENT or SIGNIFICANT OTHER is not listed, we are NOT able to speak to them.*

### *Release of Billing Information*

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

Name: ________________________________ Relationship: ____________________ Phone:____________________

Name: ________________________________ Relationship: ____________________ Phone:____________________

*Minors & Wives PLEASE NOTE: If your PARENT or SIGNIFICANT OTHER is not listed, we are NOT able to speak to them.*

### *Electronic Communication*

**Portal:** We offer secure electronic communications between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

☐ Yes, I want to Participate, my email is____________________________________________________

☐ No, I do not wish to participate at this time

*Patient Signature:*_______________________________________________*Date:*________________*Witness:*_____________________

# II. HIPAA Notice of Privacy Practices

*Patient Acknowledgement*

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review this Notice of our Privacy Practices:

Print Name: ________________________________________ Date of Birth _____________

Signature: __________________________________________ Date: ___________________

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office at *2301 Evesham Rd Suite 602 Voorhees, NJ 08043*. My revocation will be effective once received by *Women's Health Associates*, An Axia Women's Health Care Center.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Signature: ________________________________________________ Date: _________________________________

Print name: _______________________________________________ Relationship: ______________________

*Additional Information*

Race: Which category best describes your racial background? (Choose all that apply)

£ American Indian or Alaska Native
£ Native Hawaiian or Other Pacific Islander
£ Asian £ White
£ Black or African American
£ Unreported/Refused to Report

Ethnicity: How would you describe you ethnicity, such as your family background or ancestry?

£ Hispanic or Latino
£ Not Hispanic or Latino
£ Unreported/Refused to Report

Preferred Language: What language do you usually speak at home?

£ English
£ Spanish
£ Other ____________________

How did you hear about our practice?

£ Health Plan
£ Internet
£ Our Web Site
£ ER/Hospital
£ Newspaper/Magazine
£ Patient
£ Other________________________________________