Reproductive Health Associates, INC.

PATIENT INFORMATION

Last Name **First Name** **Middle Initial**

DOB: **Age:** **Social Security:** **Gender: Female Male**

Marital Status Married Single Divorced Life partner Separated Widowed Other **Language** other than English

Race ❑Black– Non Hispanic ❑American Indian/ Alaskan Native ❑Hispanic ❑Asian/Pacific Islander ❑White – Non Hispanic ❑Other

Home Address **Apt #** **City** **State** **Zip Code**

Preferred Contact Number 1 Cell Home Work **Preferred Contact Number 2** Cell Home Work

Email Address **Employment Status** Employed/Full Time Employed/PartTime Not Employed Active Duty Military Student Other

Employer **Occupation** **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician **Referring Physician**

How did you hear about us?

SPOUSE/GUARDIAN INFORMATION

Relationship to Patient **Self** **Spouse** **Partner** **Parent**

Last Name **First Name** **Middle Initial**

Date of Birth **Age** **Social Security Number**

Home Address **Apt #** **City** **State** **Zip Code**

Preferred Contact Number 1 Cell Home Work **Preferred Contact Number 2** Cell Home Work

Employer **Occupation**

Employer Phone **Employment Status** Employed/Full Time Employed/Part Time Not Employed Active Duty Military Student Other

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

DOB: **Preferred Contact Number** Cell Home Work

____

Patient Signature ____

Patient Name (Print) ____

Date ____

Reproductive Health Associates
Catherine Cowart, M.D., F.A.C.O.G.

Detailed Message

Dear Patient,

In accordance with the providers contracted by Reproductive Health Associates, blood may be drawn or other tests ordered and performed. We **MAY** need contact you after your appointment with the results of your tests or to follow up on your care. We **MAY** also need to call in reference to your appointments and financial matters. In accordance with HIPAA regulations, we need your authorization to leave a detailed message or email you with your results or questions in order to follow up on your care and financial matters, if we are unable to speak with you directly.

___ **YES** – you can leave a *detailed* message

___ **NO** – you cannot leave a *detailed* message

___ **YES** – you can leave a *general* message (office name and request a call back)

___ **YES** – I consent to receive appointment reminders via text on my cell phone.

Preferred contact number #:

Please circle: cell home

If there are any changes to the information above, you must notify our office in writing as soon as possible.
If you would like someone else to have access to your medical information and financial obligations to the office you may list their names below.

Authorized Person	Relationship to Patient
____________________	____________________
____________________	____________________
____________________	____________________

Patient Name________________________________(Please print)

Signature____________________________________Date ____________

Reproductive Health Associates
Catherine Cowart, M.D., F.A.C.O.G

HIPPA PRIVACY POLICY ACKNOWLEDGEMENT STATEMENT.

I have been informed that Reproductive Health Associates has a privacy policy in place according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a patient or parent/guardian of a patient at Reproductive Health Associates, I understand the following;

1. Reproductive Health Associates has a privacy policy in effect in our office.
2. Reproductive Health Associates has made this policy readily available to me.
3. Reproductive Health Associates has made me aware that I am entitled to a copy of this privacy policy if I desire a copy for my personal records.

After reading these statements please sign at the bottom of this sheet, acknowledging that you have been advised of the privacy policy implemented by Reproductive Health Associates and have read and understood the acknowledgement form. If you would like a copy of the privacy policy please ask for one at the front desk or print it from our website www.ivftampa.com

_____No, I do not want a copy of the policy, but I do acknowledge that is exists.

_____Yes, I have requested and been given a copy of the privacy policy.

Patient Name: ____

Patient Signature: ____

Parent/Guardian Signature: ______________________________________

For more information, please contact Reproductive Health Associates Compliance and Privacy Officer at (813) 872 – 0018.

Reproductive Health Associates
Catherine Cowart, M.D., F.A.C.O.G

INSURANCE INFORMATION

Please present proof of insurance and valid identification upon completion of this form.

Insurance Company: ____

Claims Address: ____
Street / PO Box   City   State   Zip

Telephone Number: ____

Policy/Member ID#:____________________Group #:____________________

Insured Person:____________________Relationship to Patient:____________

Insured Person's Address: ____________________________________
Street   City   State   Zip

Insured DOB:_____/_____/_____Insured S.S. #: ____________________

Insured Employer:________________________Phone #: ______________

Lifetime Assignment of Benefits and Information Release.

Patient Initial: ______

I affirm that the billing and insurance information I have provided is correct and to the best of my knowledge and I accept responsibility for keeping Reproductive Health Associates informed of any changes to this information.

Patient Initial: ______

I authorize the release of my medical information including, without limitation of information related to psychiatric care, drug abuse, alcohol abuse, STD, or HIV/AIDS, confidential information that is needed for the submission to my insurance carrier in order to process a claim or for utilization review or quality assurance activities,

Patient Initial: ______

I assign any and all medical and/or surgical benefits to which I am entitled to Reproductive Health Associates. A photocopy of this authorization shall be considered as valid as the original.

Patient Initial: ______

I agree to accept full responsibility for any copayments, deductible, coinsurance, and balances remaining after my insurance has processed claims, or for any services not covered or denied by my insurance company. If I do not have insurance coverage, I agree to pay in full for services provided at the time of service. I agree to be responsible for payment of any legal fees, court cost, and any and all other expenses incurred by or on behalf of Reproductive Health Associates in pursuit of collecting fees due for services rendered.

Patient Initial: ______

I acknowledge and agree that copayments, deductible, coinsurance, and non-covered charged are due when services are rendered. I understand and agree to pay Reproductive Health Associates a charge of $25 for failing to cancel an appointment without 24 hours' notice or a no show to an appointment, and $50 above the value of a returned check plus any and all fees associated with collecting on the returned check.

Patient Signature________________________________Date: ______________

Patient Name:____

Reproductive Health Associates
Catherine Cowart, M.D., F.A.C.O.G

APPOINTMENT & CANCELLATION POLICY.

The staff at Reproductive Health Associates respect your time and we ask for the same courtesy. Missed appointments (no shows) affect our ability to provide timely appointments for our patients. If you are unable to make your appointment, we ask that you notify our office at least 24 hours in advance. Failure to cancel an appointment will be considered a missed appointment and you will be charged a $25.00 or $50.00 fee depending on what type of appointment was scheduled.

There is also a $50 fee for any cancelled and/or rescheduled surgeries.

Acknowledgement

Patient Signature ______________________________

Patient Print ______________________________

Witness ______________________________

Date ______________________________