Women's Health Associates of Cape Cod

46 North Street • Hyannis, Ma 02648 • 508-771-7100

Geralyn Leone, MD

Patient Information & Demographics

Name: _____ Date of Birth: ____/____/____

Home Address: _____ City: _____ Zip: _____

Mailing Address: _____ City: _____ Zip: _____

Home Tel #: _____ Cell #: _____ Email: _____

Employer: _____ Occupation: _____ Work Tel # _____

Emergency Contact: _____ Relationship: _____ Tel #: _____

Pharmacy: _____ Location:_____

The following questions are asked in accordance with government compliance:

Primary Language: _____
(Must list Primary Language)

Ethnicity: ☐ Latino / ☐ Non-Latino
☐ Patient Declines to Answer

Race:
☐ Asian
☐ Native American/Alaskan
☐ African American/Black
☐ Native Hawaiian/Pac.Isl
☐ Caucasian/White
☐ Patient Declines to Answer

Medical Insurance Authorization and Assignment

I hereby authorize Women's Health Associates of Cape Cod (WHA) to release all medical records and information with respect to myself, or my dependents, which may have a bearing on the benefits payable by a payor for services rendered by WHA. I understand that I cannot retract this authorization for the release of medical records until my account balance if fully satisfied. I understand I am financially responsible to WHA for any co-pays, deductibles or charges not covered by any insurer. I acknowledge that WHA can charge a service fee of $35.00 to my account in the event that I remit payment for services with a check that is returned due to insufficient funds. I understand WHA reserves the right to collect all charges related to patient accounts placed into collections including but not limited to collection agency fees, attorney fees and court costs. I understand and agree to pay interest at the rate of one and one-half percent (1.%) per month, eighteen (18%) percent per year, until the entire balance is paid in full. I assign directly to WHA all medical benefits payable to me for services rendered on my behalf, or my dependents behalf. I authorize the use of this signature for all my insurance submissions as well as any records I may request for my personal use I understand that my co-pays, deductible and co-insurance are due at the time of service, unless other arrangements are made with WHA.
All patients without insurance coverage are required to make payment at the time of service.
Patient

Missed Appointment Fee

I understand that I am responsible for a $25 charge, if I fail to cancel a scheduled appointment which I am unable to attend 24 hours prior to said appointment.

Acknowledgement of Receipt – HIPAA Notices of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used or disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I authorize Women's Health Associate of Cape Cod to contact me by the following methods: Appointment reminder mailings, Call home/Leave message to confirm appointments, Call home with Testing results, call mobile/cell phone with appointment reminders and or testing results, email. WHA may utilize the contact information listed above to contact me unless otherwise stated below:
I only wish to be contacted via_____

I understand and agree to the above:

Signature: _____ **Date:**_____