Austin Springs Women's Health

NEW PATIENT PAPERWORK

Please fill out your paperwork completely to avoid a delay in your check in process.

Identification/Provider:

Legal Last Name:	Legal First Name:
Middle Name:	Date of birth:
Preferred Name:	

Contact Details:

Email:	Mobile Phone:
Address:	Home Phone:
City, State and Zip:	Work Phone:
Secondary Contact Name:	Relationship:
Mobile Number:	Can we leave a detailed message? YES NO

Demographics:

Language Preferred:	Race:
Gender Identity?	Ethnicity:

Insurance:

Primary Insurance:	**Subscriber ID:**	
Primary policy holder name:		Group ID:
Primary policy holder DOB:		Relationship:
Claims Address:		

Primary Provider Information:

Previous Providers:	
Primary Care Provider:	
Phone Number:	Fax Number:
Previous Gynecologist:	
Phone Number:	Fax Number:

Pharmacy:

Pharmacy Name:	**Phone:**

Privacy Acknowledgment Consent

HIPAA-ACKNOWLEDGEMENT OF RECEIPT-PRIVACY NOTICE

Due to the Health Insurance Portability and Accountability Act of 1996, the following information must be completed and updated ANNUALLY by each patient. Please log into: www.austinspringwomenshealth.com for a copy of Notice of Privacy Practices. I have been given the opportunity to reach and receive a copy of Austin Springs Women's Health (ASWH) Privacy Policy. I understand that Austin Springs Women's Health will only use/or disclose protected health information for treatment, payment, or healthcare operations.

Release of Billing Information

I authorized Austin Springs Women's Health to release any information acquired during my treatment to my insurance company, employers, institutions, or third parties, as required by certain claims fields. I understand I am responsible for payment(s) such as copayments, deductibles, coinsurance and in and **out of network** charges. I hereby assign to the provider all payments for medical services rendered. I am aware that current and past due payments are due at time of service unless prior arrangements have been discussed. I understand and give consent for any outstanding charges past 90 days to be sent to the following collection agency: Merchant and Professional Collection Bureau, which will report to all three credit bureaus: Transunion, Experian, Equifax.

Assignment of Benefits

With this form I acknowledge that I have been provided a copy of the Notice of Privacy Practices of Austin Springs Women's Health or choose to view them on my provider's home website: www.austinspringswomenshelath.com I authorize the release and disclosure of portions of my medical records necessary for myself. This authorization gives ASWH the right to request and receive medical information from other healthcare entities to include, but not limited to, copies of labs and imagining results, clinical information deemed necessary by ASWH, it's physicians and representatives. I may inspect my protected health information, request more information, and revoke this authorization as permitted by the Federal Privacy Regulation and in accordance with ASWH Privacy Policy.

Medication Authority Consent

Austin Springs Women's Health requests the authority to download the patient's medication history automatically from pharmacy benefit managers (PBMs) to receive the most up-to-date medication list with dosages. This allows your providers to view your current medication list to confirm no drug adverse reaction to new medications prescribed during your visit. If you wish to remove this consent. Please notify the front desk immediately so we can turn off the transfer.

Consent to Call:

Austin Springs Women's Health (ASWH) will use the information provided above to be entered in Athena Health electronic medical records (EMR) platform as their check-in process. I consent for ASWH to send me a link so I may register for my patient portal. This consent to contact includes entry of any telephone contact number that constitutes written consent and received automated, pre-recording, text message and artificial voice telephone calls initiated by the Practice. I may alter or revoke the consent by visiting the Patient Portal "contact preference".

HMO Plan/Prior Authorization/Referral

It is the patient responsibility to know their benefits. Please contact member service number on the back of the insurance card. Your insurance representative will go into detail with your benefits and inform you of your patient responsibility. It is the patient's responsibility to retrieve a referral from their primary care provider **prior** to your appointment with your provider. If a referral is not present and your claim is denied. **You will be responsible for all denied claims. Please call your medical insurance provider prior to your visit to obtain your benefits.**

Insurance Benefits

It is YOUR responsibility to inform us of any changes with your insurance at the time of your appointment. We encourage you to call your insurance company determine if your insurance is **participating with Austin Springs Women's Health**. Many insurances have "timely filing deadline". If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered. Please keep in mind that your insurance card is a **CONTRACT** between you and the insurance company. Not all insurances cover all procedures, preventative care, labs or imaging. We do not call benefits prior to your visit. It is your responsibility to know what services may or may not be covered by your insurance prior to your visit.

Patient Signature: _____ **Date:** _____

Austin Springs Women's Health

Office Policies

Insurance Card/Identification Card

A current insurance card is required at every appointment and a valid ID (not expired) is vital in ensuring that services are billed correctly. If a patient does not have a current copy of her insurance card, you have the option of paying in full for that day. Once received, we will bill the insurance and refund self-pay amount once claim is paid by your insurance company.

Patient Portal:

In the event you have registered for your patient portal, we may leave a detailed message of any abnormal labs results, imaging and/or medical information by referring to a case or reference number. Please give the case/reference number to the front desk so anyone in the office will be able to better assist you. All normal labs **will not** be called but published via patient portal.
In the event we need to call you; the phone number you wish for us to leave a detailed message is: _____.

Lab Services:

ASWH utilized a **separate entity** laboratory: **Pathgroup Laboratories,** which accept most insurances. If you desire to utilize a different laboratory, please notify front desk at your check-in before being brought back. You will be billed separately for your blood work, pathology, and cultures. You can contact their billing department for any questions or concerns at: 888-474-5227.

Prescription Medication Policy & Agreement:

The following is an outline of our prescription medication refill policy for Austin Women's Health Providers.

- **Refill Request**- Please call your pharmacy first. Please be aware we **cannot** refill medications after hours or on weekends. Make sure you contact your pharmacy **14 days** before you run out of your medication. The pharmacy will then fax and call us the information we need to be able to determine if you are authorized for a refill.
    - **Birth Control:** ASWH provides twelve-month refills. Please make sure you are scheduled for your well woman exam prior to your last refill. No refills will be approved until you have seen your provider for a wellness exam.
    - **Hormone Refill:** ASWH provides six-month refills. No refills will be approved for HRT over the phone or through your pharmacy's request. You must make an appointment for an HRT refill.
    - **Pain Medication Refills:** For all pain medication refill, you must make an appointment to re-evaluations prior to a refill.

Outstanding Orders:

Please be advised, Austin Springs Women's Health will attempt to call you 3 times on 3 different days to remind you of your outstanding order. Once attempts have been exhausted, your lab/imaging/referral order will be closed.

Termination of Doctor-Patient Relationship

Our office values its patient relationship and want to protect patient's right. We will terminate the patient relationship with cause and after careful consideration. Reasons for termination include repeatedly not showing up to scheduled appointments, not complying with recommended medical card, requesting medical records to another OBGYN, being hostile or abusive to staff, not paying past due balances within 6 months of statement.

Patient Signature: _____ **Date:** _____

Austin Springs Women's Health

FINANCIAL POLICIES

Uninsured Patients

We require all payments at the time of services are rendered. New Patients: $250 Established Visit: $150. Please be advised labs, imaging, procedures & surgeries are separate from your office visit. Any ancillary labs/imaging performed in the office will need to be paid in full at check out. Please confirm with the front desk if there are any additional charges. Please be advised, once claim is created, the outstanding amount past due will be collected from the credit card on file within 3 business days.

Convenient AutoPay

Retain your credit card on file in a safe encrypted environment. This feature is available to ensure all our payments are received on time and helps you avoid administrative fees if paid after 45 days. By enrolling in Convenient Auto-Payment, we will be able to collect your copayment up front any outstanding balances 5-7 days from when you receive your statement via patient portal, email and/or phone/text message.

Third Party Payers

Our office does not bill third party payers (TPA) such as, PIP (Personal Injury Protection) for a motor vehicle accident or attorneys.

Returned Checks

Please be advised we do not accept cash or checks in the office. Checks returned to us by the bank will assess a returned check fee of $75 in addition to the original amount of the check.

Late Policy

We are committed to prompt service, and will work extremely hard, barring emergencies, to stay on time. Both new patient and established patients are expected to arrive 15 minutes earlier from their scheduled appointment time. This allows the Medical Assistant to perform your intake and vitals, so you can see the provider at your scheduled time. If you are 10 minutes late to your appointment, you will be rescheduled to a later time or another day depending on the availability & incur a $50 inconvenience fee. Please make sure you have your photo ID and Insurance Card at check in.

Deductible/Copayment Payments

All payments are due at the time of service. We encourage our patients to call the 800-phone number in the back of the insurance card to go over your benefits and patient responsibility. High Deductible Plans: Deposit of $100 will be collected at time of service. Copayment will not be waived and it due at time of service.

We accept Debit and Credit Cards ONLY. No cash or checks accepted.

Past Due Balance Admin Fee

Any outstanding balances, including deductibles, are due within 30 days of the statement. If payment is not received within 45 days, an administrative fee of $25 will be assessed on the account.

Collections Account

All balance reaching 90 days past due will be sent to our collection agency Syncom also known as Synergetic Communication Collection Agency & will be reported to the following collections agencies: Transunion, Experian and Equifax. If you experience circumstances beyond your control, please contact our billing office and we will be more than happy to make payment arrangement. ALL statements and/or outstanding balances are available via your patient portal. Please be advised we are electronic; a courtesy paper statement will be mailed to the address on file. All other reminders of past due balance will be in located via patient portal.

Patient Signature: _____ **Date:** _____

Austin Springs Women's Health

Financial Policies:

Missed Appointments

We understand there will be times when a scheduled appointment cannot be kept. If you need to cancel or reschedule an appointment, we require that you notify our office **24 hours in advanced** to avoid a cancellation/rescheduling fee.

- No show or Missed Appointment: Requires 24 hours' notice (New patient or Established Patients): **$50 cancellation fee**.
- Missed Ultrasound appointments: Requires 24 hours' notice: **$75 cancellation fee**.
- Surgery from an outside facility: Requires 7-business day notice: **$200 cancellation or rescheduling fee.**
- Procedure Appointment: Requires 48 hours' notice: **$150 cancellation fee.**

After-Hours Services

If you need a provider to call you after 4:30 pm Monday-Friday or on the weekend, we provide after-hour virtual/telehealth services. This is a nominal fee of $75 and will be billed as self-pay & collected at the time services are rendered by credit card on file. A provider will call you within 2 hours of leaving a message with the on call answering service.

If you have an emergency, such as chest pain, severe shortness of breath, severe headache, or bleeding, call 911 or proceed directly to the nearest hospital emergency department.

You can always send a patient portal message with any questions about acute medical problems after hours and receive a quick response at no charge with your provider. If the physician is not in the office, please call: **On Call Service: 512-229-9505.**

Medical Record Release and & Form Fees

We will provide copies of your medical records within 14- business days of signed record release and the nominal charge.

- Provider to Provider Records release: **No charge**.
- Patient's Request to obtain medical records: **$25 fee.**
- FMLA, Disability, Health Certificates or Miscellaneous Paperwork: **$25 fee**.
- Legal paperwork: **$75 fee**

Patient Signature: _____ **Date:** _____

Austin Springs Women's Health

Credit Card on File Policy

Maximum Charge in 365 days: $3000

This is not a receipt. This is an agreement agreeing to pay for services once patient liability has been determined. The terms of this agreements are outlined below.

Agreement Terms:

Effective Date: Your first day of scheduled appointment

Expiration Date: One year from your first scheduled appointment

I agree to allow the practice to charge my card during the effective period for the balance due, as determined by the final adjudication of all claims including under this contract. I agree to the final adjudication amount as defined by my insurance company, with exception as noted below. I agree to these charges under the following conditions:

- The amount charged to my card will not exceed the agreed-upon maximum dollar amount.
- My credit card will be stored by Elavon, Inc., a secure credit card processor affiliated within U.S. Bank that partners with the practice to collect payments.
- I will receive a bill from the practice via patient portal for any balances greater than the maximum dollar for which I am liable once the transaction has been executed.
- My credit card on file will be utilized for any and all outstanding bills/invoices on my account 5-7 days after the statement as been release for viewing.
- I may cancel this agreement at any time by contact the practice.

We have implemented a policy requiring a credit card held on file effective 01/01/2025. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring cost to you, the insured. Some insurance plans required deductible and copayment in amounts not known to you or us at the time of your visit. Like hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be securely until your insurance has paid their portion and notified us of the amount of your share, you will receive a statement. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you. This is an advantage since it makes checkout easier, faster, and more efficient. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of the payment. If you have any questions about this payment method, do not hesitate to ask.

By signing below, you have read entirely and fully understand and accept patient's responsibility, office policies and protocols. To remove your credit card on file, please call our administration to remove card on file.

Patient Signature: _____Date: _____

Patient Signature: _____ Date: _____

TREATMENT CONSENT

Austin Springs Women's Health and its providers, medical staff and administration places a high priority on customer service. We are available to answer your non-emergency calls, from 8:00 AM to 4:30 PM, Monday through Thursday & 08:00 A.M to Noon on Fridays. **After hours what do you do? Call: 512-229-9505.** For emergency situations, dial 9-1-1 or go to the nearest Emergency Room. Due to a high call volume, we encourage our patient to send correspondence via patient portal for a quicker response time. Please allow up to 24 hours to respond.

Consent for Treatment

I hereby voluntarily consent for treatment. I permit Austin Springs Women's Health, and its providers, employees, medical staff, and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to **withdraw my consent for treatment or tests.**

I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician.

I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care, or examinations in the facility.

Nurse Practitioner Consent for Treatment

This facility has on staff a Nurse Practitioner to assist in delivery of medical care. Nurse Practitioners are not doctoring. A Nurse Practitioner is a Registered Nurse licensed under the Board of Nursing, who has received advanced education and training in the provision of health care. Under the supervision of a physician, a Nurse Practitioner can diagnose, treat, and monitor common acute and chronic disease as well as provide health maintenance care. “Supervision” does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided. These services may include but not limited to: obtaining histories and performing physical exam, ordering and/or performing diagnostics and therapeutic procedures, formulating a working diagnosis, developing and implementing treatment plan, monitoring the effectiveness of therapeutic inventions, offering counseling and education, supplying sample medications and writing prescriptions, making appropriate referrals, providing prenatal care and women’s health, and performing office procedures (i.e. Nexplanon insertion, IUD placement and removal, colposcopy, EMB, skin biopsies).

Telehealth Consent:

I consent to treatment involve the use of electronic communication to enable health care providers at different location to share my individual patient medical information for diagnosis, therapy, follow up, and/or education purposes. I consent to forward my information to a third party as needed to receive my telemedicine services, and I understand that existing confidentiality protections apply. I acknowledge that while telemedicine can be used to provide improved access to medical care, as with any medical care, as with any medical procedure, there are potential risks, and no results can be guaranteed or assured. These risks include but are not limited to technical problem with information transmission; equipment failures that could result in lost in information or delays in treatment. I understand that I have a right to withhold or withdraw my consent to the use of telemedicine during my care at any time. I do understand, this is still a doctor’s visit, and I am fully responsible for my copayment or deductible responsibility.

The undersigned certifies that I am the patient or authorized to sign on behalf of the patient. I have read the foregoing, understand it, accepts its terms & have received a copy of it. I agree with all the privacy acknowledgment consent, office policies, financial policies

Patient Signature: _____ **Date:** _____