Alliance
Obstetrics & Gynecology

PRIVIA
WOMEN'S HEALTH

Patient Information

Demographics

Name: DOB: Age:

SSN: Ethnicity:

Home Address: City: State: Zip:

Cell #: Home #:

Email: Marital Status:

Emergency Contact: Relation & Phone:

How did you hear about us?

Primary Doctor: Primary Phone:

Insurance – <u>Policy Holder's</u> Information

Name: DOB: SSN:

Pharmacy

Pharmacy Name: Pharmacy Phone:

Pharmacy Address:

Office Policies Signature Page

I acknowledge that I received a copy of the *Alliance Obstetrics & Gynecology Group, LLC,* Office Policies dated June 1, 2020 prior to signing this form. I have had adequate time to review the policies and agree to the terms as listed within. I have been given an opportunity to ask questions and understand that a copy of the Office Policies are available on the practice's website (www.allianceobgyngroup.com) or upon request.

_____ _____

Patient Printed Name Date

_____

Signature of Patient

Pelvic Examination Consent Form

Patient Name: _____ Date of Birth: _____

- **CONSENT:** I, the above listed patient or the legally authorized person for the patient, hereby consent to receiving pelvic examinations (as medically necessary) being performed by my physician or other health care practitioners affiliated with them, including any student receiving training as a health care practitioner.

- **NATURE OF PELVIC EXAMINATIONS:** For the purposes of this Consent Form, a "pelvic examination" on a female means the series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation. For purposes of the Consent Form, a "pelvic examination" on a male means examination of the rectum, prostate, and external tissue or organs, including the penis or scrotum using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

- **DURATION:** I understand that this consent form shall be valid for any current or future visits until such time as I request, in writing, to withdraw my consent. I acknowledge that I have the right to refuse a pelvic examination at any time by any person with the exception of an examination per a court order for the collection of evidence or if an examination is immediately necessary to prevent a serious risk of imminent, substantial, and irreversible impairment.

I CONSENT TO RECEIVE PELVIC EXAMINATIONS AS DESCRIBED ABOVE, AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____
Patient or Legally Authorized Name *Relationship to Patient*

_____ _____
Signature *Date*

_____ _____
Witness Name *Role*

_____ _____
Witness Signature *Date*

Alliance Obstetrics & Gynecology

PRIVIA WOMEN'S HEALTH

Authorization and Consent to Treat

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges. If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being. If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time. My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

HIPAA. I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE, and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.*

Printed Name of Patient: _____ **Email:** _____

Signature: _____ **Date:** _____

Name and Relationship of Person Signing, if not Patient: _____

Preferred Method of Contact & Information Disclosure

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. If your preferences change, you may change this information at any time, in writing.

Patient Name: _____ **Date of Birth:** _____

I prefer to be contacted in the following manner (check all that apply):

☐ **Send all communication through my Patient Portal**

☐ **Home Telephone:** _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Cellular Telephone:** _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Work Telephone:** _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Written Communication:**

- ☐ Please send all of my mail to my home address on file

Preferred Contacts:
We respect your right to tell us who you want involved in your treatment or to help with your payment issues. You may use this form to name specific individuals with whom you want us to share your information. This may include information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up and scheduling appointments. **Please update this information in writing if your preference change.** Please note that we may share your information as set forth in our Notice of Privacy Practices to other persons not named on this form as needed for your care or treatment or the payment of services we have provided. Please indicate the person(s) you prefer we share your information with below:

• **Name:** _____ **Telephone:** _____ **Relationship:** _____

• **Name:** _____ **Telephone:** _____ **Relationship:** _____

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)