



Dear Patient,

Thank you for choosing Azalea Gynecology. Our all-female staff has been providing exceptional healthcare for women since 1996. We hope that you will find our providers and other personnel meeting and exceeding your expectations.

Please complete the enclosed forms and bring them with you the day of your scheduled appointment. Also, remember to bring your insurance card, a photo ID and your co-pay, if applicable, with you each time you come to our office.

Please make us aware of any special concerns you may have so that we may better serve you. If you have any questions regarding these forms or your visit, please do not hesitate to call our office.

We look forward to seeing you!

Sincerely,

The staff of Azalea GYN

P.S. — We are pleased to announce the expansion of our services to include laser aesthetic treatments, hair removal and skin rejuvenation. These procedures are performed effectively and safely in our clinical setting.

**1814 New Hanover Medical Park Drive
Wilmington, NC 28403
Telephone: 910-452-3666
Fax: 910-397-0930**



PATIENT ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE

1. I acknowledge that I have received or have been offered a copy of Azalea Gynecology Notice of Privacy Practices, effective April 14, 2003. _____(Initial)
2. I acknowledge my right and have been offered the option to request to receive communications of my personal health information by alternative means or at alternative locations. I understand that Azalea Gynecology may refuse to accommodate my request if it is not reasonable. _____ (Initial)
3. Please indicate the address and telephone number you would like our office to use for appointment reminders or other office communications (**including but not limited to billing matters, pap smear and mammogram results**). All other test results require direct communication with our staff.

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

4. Is there a family member or friend that you will allow us to leave messages with or release billing or medical information to? _____ N/A / None

Name: _____ Phone: _____

Name: _____ Phone: _____

A current Notice of Privacy Practices for Azalea Gynecology is also available at the check-in counter.

Print Name

Date

Signature of Patient or Patient Representative

Relationship of Representative/Authority to act on behalf of the Patient

AZALEA GYNECOLOGY

1814 New Hanover Medical Park Drive
 Wilmington, NC 28403
 910-452-3666

PATIENT DEMOGRAPHIC WORKSHEET

PATIENT	PATIENT NAME	MARITAL STATUS	DATE OF BIRTH	SEX	AGE	RACE	
	STREET ADDRESS					APT/SUITE#/PO Box #	
	City		STATE	ZIP		SSN	
	PATIENT HOME PHONE		EMERGENCY CONTACT			EMERGENCY CONTACT PHONE	
	PATIENT EMPLOYER/SCHOOL NAME		PATIENT OCCUPATION (IF STUDENT, INDICATE FULL TIME OR PART TIME)			PATIENT WORK PHONE	
	PATIENT EMAIL ADDRESS		REFERRED TO THIS PRACTICE BY:			PATIENT MOBILE PHONE	
RESP PARTY	RESP PARTY NAME		RELATIONSHIP TO PATIENT			RESP PARTY HOME PHONE	
	STREET ADDRESS					APT/SUITE #	
	City		STATE	ZIP CODE		RESP PARTY MOBILE PHONE	

INSURANCE INFORMATION

INSURANCE	PRIMARY INSURANCE		EFFECTIVE DATE	ID /GROUP NUMBER			
	POLICY HOLDER NAME		RELATIONSHIP TO PATIENT	POLICY HOLDER DATE OF BIRTH		POLICY HOLDER SOCIAL SECURITY NUMBER	
	POLICY HOLDER EMPLOYER NAME			RESP PARTY WORK PHONE			
	SECONDARY INSURANCE		EFFECTIVE DATE	ID / GROUP NUMBER			
	POLICY HOLDER NAME		RELATIONSHIP TO PATIENT	POLICY HOLDER DATE OF BIRTH		POLICY HOLDER SOCIAL SECURITY NUMBER	
	POLICY HOLDER EMPLOYER NAME			RESP PARTY WORK PHONE			
	PHARMACY NAME AND LOCATION			PHARMACY PHONE NUMBER			

FINANCIAL POLICY

FINANCIAL	<p><u>I UNDERSTAND THAT AZALEA GYNECOLOGY REQUIRES PATIENT AND POLICYHOLDER SOCIAL SECURITY NUMBERS ON ALL ACCOUNTS, IF NOT PAYMENT IS DUE IN FULL AT TIME OF SERVICE. IT IS ALSO OFFICE POLICY TO OBTAIN DRIVERS LICENSE OF PATIENTS 18 YEARS OF AGE AND OLDER OR THE RESPONSIBLE PARTY IF UNDER THE AGE OF 18.</u> I UNDERSTAND THAT IF I DO NOT HAVE A VALID AUTHORIZATION FROM MY INSURANCE COMPANY TO COVER SERVICES PERFORMED OR AZALEA OB/GYN DOES NOT PARTICIPATE WITH MY INSURANCE COMPANY, I WILL BE PERSONALLY RESPONSIBLE FOR THE CHARGES IN FULL, AND I AGREE TO PAY, IN FULL, ANY CO-PAYS, DEDUCTABLES, OR CO-INSURANCE AMOUNTS THAT MY INSURANCE COMPANY DEEMS MY RESPONSIBILITY, INCLUDING THOSE RESULTING FROM MY FAILURE TO OBTAIN THE NECESSARY REFERRALS AND/OR OTHER AUTHORIZATIONS FROM MY PRIMARY CARE AND/OR REFERRING PHYSICIAN WHEN REQUIRED. FAILURE TO COMPLY WITH THIS FINANCIAL POLICY MAY INCLUDE COLLECTION ACTIVITY AND LEGAL ACTION. ANY FEES INCURRED IN THE COLLECTION OF AN OUTSTANDING DEBT WILL BE IN ADDITION TO THE DEBT AND THE PATIENTS RESPONSIBILITY. <u>PLEASE NOTE: ALL TESTING DONE OUTSIDE OF THIS OFFICE WILL BE BILLED BY THE LABORATORY OR TESTING FACILITY TO YOU OR YOUR INSURANCE COMPANY. THE CHARGE FOR THIS TESTING IS ADDITIONAL TO YOUR OFFICE VISIT CHARGES AND WILL BE BILLED TO YOU BY THE OUTSIDE FACILITY. ALL PATIENTS WHO CANCEL, NO SHOW OR RESCHEDULE WITHIN 24 HRS. OF THEIR SCHEDULED APPOINTMENT WILL BE CHARGED A \$25 NO SHOW FEE. BE ADVISED THAT CANCELLATIONS OR RESCHEDULES CAN ONLY BE ACCEPTED MONDAY - FRIDAY 8:30AM - 5:00 PM.</u></p>	
	<p>SIGNED: _____ DATE: _____</p>	

AUTHORIZATION

CONSENT	<p>I HEREBY AUTHORIZE THIS PRACTICE TO RELEASE INFORMATION TO MY INSURANCE COMPANY. I ALSO AUTHORIZE THIS PRACTICE TO RELEASE MY MEDICAL INFORMATION, INCLUDING PRIVILEGED, SENSITIVE INFORMATION, TO ANY HOSPITAL, PHYSICIAN OR PROVIDER THIS OFFICE AND MY PRIMARY CARE PHYSICIAN MAY REFER ME TO. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN AND I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE CLAIMS FORMS. I AUTHORIZE A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.</p>	
	<p>SIGNED: _____ DATE: _____</p>	

Patient Name:

Welcome to Azalea Gynecology! We are pleased that you have chosen us to provide you with your medical care.

HOURS: 8:30 am – 5:00 pm Monday – Friday.

APPOINTMENTS: All patients are seen by appointment only. We will call to confirm all appointments except Laboratory appointments 3-4 days prior to your appointment. Due to the nature of our practice, we may need to occasionally reschedule an appointment you have made and we appreciate your understanding should this be the case. We ask that you give us at least 24 hours notice if you need to reschedule. **ALL PATIENTS WHO CANCEL, NO SHOW OR RESCHEDULE WITHIN 24 HRS. OF THEIR SCHEDULED APPOINTMENT WILL BE CHARGED A \$25 NO SHOW FEE. BE ADVISED THAT CANCELLATIONS OR RESCHEDULES CAN ONLY BE ACCEPTED MONDAY – FRIDAY 8:30AM – 5:00 PM.**

TELEPHONE: During office hours our clerical staff answers our phone, however during the lunch hour (noon – 1pm) please follow the telephone prompts for voicemail. If you have a medical question or concern, our staff will take your information, and our nursing staff will return your call. After office hours, a physician is on call at all times. If you feel you have an emergency that cannot wait for regular office hours, go to the nearest emergency room and they will contact the on-call physician. For urgent issues that must be addressed outside our normal office hours, call the office and listen to the answering machine for instructions.

PRESCRIPTION REFILLS: Contact your pharmacy first to determine if you have any refills remaining on your prescription. If not, request that the Pharmacist call our office for a refill or you may call the office to request one. Our physicians usually address refills within 24-48 hours.

INSURANCE: We participate with several major insurance carriers and we will file your insurance claims as a courtesy. However, it is your responsibility as the insured to determine if we are a network provider for your insurance carrier. Verification of eligibility by our office for benefits does not ensure payment for the services provided. Our practice is committed to providing the best treatment possible for our patients and we charge what is usual & customary for our area. You are responsible for payments in full regardless of any arbitrary determination of usual & customary rates. All co-payment, deductible, and coinsurance amounts are due prior to services and you will be billed after your visit for any additional amounts your insurance carrier determines to be your responsibility. If you are insured by a carrier that we do not participate with, you will be asked to pay in full at the time of service and will be given an insurance claim form as a courtesy to submit to your insurance carrier for reimbursement.

WELLNESS: Some of the insurance carriers have plans that cover wellness exams. A wellness exam is scheduled when a patient calls and is in need of her annual gynecologic physical exam including a Pap smear and breast exam. You will need to contact your insurance carrier to determine if your policy covers these types of exams. If you are having a specific problem not related to routine care, this is not considered a “wellness” exam and cannot be filed with your insurance carrier as such. Problem visits are scheduled separately from a wellness exam. Please remember, you are responsible for knowing whether you have wellness coverage. Wellness visits and Problem visits cannot be combined and will be scheduled appropriately.

SELF-PAY: Self-Pay patients are defined as patients without any medical coverage. As such, you will be required to pay an upfront fee prior to service based on the appointment type. However, you may incur additional fees based on the services performed during the visit. These fees will be required to be paid in full at the completion of your visit.

TEST RESULTS: Azalea Gyn patients will be notified of all test results unless otherwise specified. Please be advised that if you have not heard from us within the timeframes furnished, it is your responsibility to contact our office for your results.

Pap Smears	4 weeks
Ultrasounds	1 week
Blood Testing	1 week
Mammograms	within 2 weeks of testing.

FINANCIAL POLICY: You are responsible for determining if our practice is a participating provider with your insurance carrier. You will be personally responsible for the charges in full at the time of service if we do not participate. You are responsible to pay, in full, any co-payments, deductibles, or co-insurance amounts that your insurance company deems your responsibility. **I UNDERSTAND THAT AZALEA GYNECOLOGY REQUIRES PATIENT AND POLICYHOLDER SOCIAL SECURITY NUMBERS ON ALL ACCOUNTS, IF NOT PAYMENT IS DUE IN FULL AT TIME OF SERVICE. IT IS ALSO OFFICE POLICY TO OBTAIN DRIVERS LICENSE ON PATIENTS 18 YEARS OF AGE AND OLDER OR THE RESPONSIBLE PARTY IF UNDER THE AGE OF 18.** Failure to comply with this financial policy may result in collection activity and legal action. Any fees incurred in the collection of an outstanding debt will be due in addition to the outstanding debt and the patient’s responsibility.

I have read and agree to the above information _____ **Date:** _____

Signature

Directions to: Azalea Gynecology & Azalea Laser and Skincare

