HENNESSEY
Obstetrics & Gynecology

Michael H. Hennessey, M.D. F.A.C.O.G., Kelsie Yang, PA-C, Megan Dixon Sherman, PA-C

Today's Date: _____

Last Name: _____ Maiden Name: _____

First Name: _____ Middle Initial:_____

Please Circle: Single / Married / Separated / Divorced / Partner / Widowed

Race: _____ Ethnicity: ☐ Hispanic or Latino ☐ **NOT** Hispanic or Latino

Address: _____

City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone:_____

Work Phone: _____ Email:_____

Social Security Number: _____ Date of Birth:_____

Employer: _____ Primary Care Physician: _____

INSURANCE INFORMATION:

Primary Insurance:_____

Member ID or Policy Number:_____ Group Number:_____

Name of Policy Holder: Last :_____First:_____ M.I. ____

Please Circle Relationship to patient: Self / Spouse / Parent

Address of Insured:_____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Work Phone:_____

Social Security Number:_____ Date of Birth:_____

Emergency Contact:_____

Relationship:_____Phone Number:_____

Other Contact:_____

Relationship:_____Phone Number:_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Including HIV, STD, and AIDS related information

Patient Name:_____ Date:_____

SSN:_____ DOB:_____ Phone:_____

I hereby authorize (Physician Name, Complete Address, and Phone Number):

_____

_____

_____

To release information from medical records for treatment during the period from _____ to _____. Please include all portions of the medical records including laboratory and radiology studies. The above records will include any information regarding HIV, STD, and AIDS related testing or treatment, drug, and/or alcohol abuse, and psychiatric treatment to be released to Northwest Florida Woman Care-907 Mar Walt Drive Suite 2024, Fort Walton Beach, FL, 32547 OR 4554 Highway 20 East, Niceville, FL 32578.

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for this purpose.

_____ _____

Patient's Signature OR Legally Authorized Representative Date

If the patient is a minor and/or incapacitated, authorization must be signed by the parent of legal guardian. If the patient is deceased, authorization must be signed by the next of kin or executor or proof of same.

_____ _____

Witness Date

TEXT MESSAGES/VOICE If I am unreachable, NWFLWC physicians or staff ☐ **may** ☐ **may NOT** leave voice messages or send text messages.

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PERSONAL RELEASE OF INFORMATION -As part of the HIPPA Privacy guidelines, we are NOT allowed to discuss your PHI (personal health information) with anyone such as your spouse, parents or friend without your written permission. You may elect to allow NWFLWC physicians or staff to release or discuss your protected health information.

☐ **ALLOW**- Release information to person(s) below ☐ **DO NOT RELEASE MY INFORMATION**

YOU MUST LIST FULL NAMES OF EACH PERSON(S)

Name:_____DOB:_____

Name:_____DOB:_____

CONSENT TO CONTACT - We offer a Patient Portal to all of our patients. This allows you to access your patient chart, results of labs, tests and procedures. You can also send us questions, requests refills and check appointments through the portal. Please provide your email if you wish to have access the patient portal. **Initial:**_____

Email:_____

CANCELLATIONS AND MISSED APPOINTMENTS - Office appointments canceled with less than 24 hour notification and patients who do not show up for their appointment will be subjected to a **$25.00** fee for an office appointment and a **$100.00** fee for a procedure. Patients who No-Show (2) or more times in a 12 month period may be dismissed from the practice and will be denied future appointments. We do understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees may be waived with Management's approval.

Initial:_____

ELECTRONIC PRESCRIPTIONS CONSENT - Our office uses electronic prescriptions. Your provider will send your prescription to the pharmacy electronically, expediting the processing of your medications and reducing the chance for errors. This also allows us to obtain the medications that have been prescribed to you over the past 13 months.

Accepts ☐ **Declines** ☐

What **PHARMACY** do you use?_____

What **LAB** do you use? _____

FLORIDA SHOTS PROGRAM - I authorize NWFLWC to access my immunization record through the Florida Shots program. **Initial:** _____

PRIVACY POLICY NOTICE - I have received the NOTICE OF PRIVACY PRACTICES from Northwest Florida Woman Care. **Initial:**_____

LIFETIME INSURANCE AGREEMENT & AUTHORIZATION - I authorize payment directly to Northwest Florida Woman Care, benefits otherwise payable to me by my insurance company. I do hereby assign Northwest Florida Woman Care, any benefits, payments, or proceeds from any insurance company who is or may be liable at any time for all or part of my charges on this account to the extent necessary to such charges in full. If my insurance does **NOT** pay the physician directly, I agree to pay Northwest Florida Woman Care amounts equal to all health insurance benefits, which I receive for medical care, immediately upon receipt of such payments. I authorize Northwest Florida Woman Care to release my insurance carrier or its representative any information needed from my medical records concerning the examination and treatment rendered to me that is neccesary to process the insurance claim. **Initial:** _____

FINANCIAL RESPONSIBILITY - I acknowledge I am responsible for **ALL** charges and/or services, which were provided by Northwest Florida Woman Care whether incurred in the past or future, including any amount not paid or covered by my insurance. I understand Northwest Florida Woman Care will **NOT** take responsbility for negotiating the settlement of disputed insurance claims. I agree to pay the charges for care provided to me within (30) days of the first monthly statement. Amounts beyond this time may be assessed a penalty and may be applied to the balance, unless other agreements have been made through the billing department. **Initial:**_____

Patient's Name (Please Print): _____

Patient's Signature:_____Date:_____

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HIPAA MINOR CONSENT FORM

(if patient is 17 years or younger)

In accordance with HIPAA law all minor's records will be made available to the parent or legal guardian upon request. This record will include all personal health information that has been discussed with your provider at any appointments you have had. In addition if you are a dependent listed on your parent or legal guardian's insurance plan they reserve the right to view the type of care you have received by way of billed insurance claims.

By signing below you will acknowledge that you have been provided with this information and understand that your personal health information can at any time be provided to your parent or legal guardian.

_____
Print Name (Minor)

_____ _____
Patient Signature (Signature of Minor) Date

_____
Print Name (Parent or Legal Guardian)

_____ _____
Signature (Parent or Legal Guardian) Date