ALL ABOUT WOMEN OBGYN
70 Doctors Drive Panama City, FL. 32405
Office: 850-785-1517, Fax: 850-784-1271 web: www.aawob-gyn.com
Stephen G. Smith, M.D., Tricia M. Percy, D.O., Roslyn V. Mallory, M.D.
Timothy J. Ramsden, M.D., Charlie N. Kelly, ARNP-BC

0Date_____

Marital Status Single_____ Married_____ Widow_____ Divorced_____ Race_____

Patient's Full Name_____ Preferred Name_____

Birthdate_____ Social Security #_____

Mailing Address_____Apt#_____

City, State, Zip Code_____

Home Number_____Work Phone_____Cell Phone_____

Email_____ **PHARMACY** / Location_____

Patient's Employer _____Employer's Phone #_____

Name of Primary INSURANCE Carrier_____

Contract/ID/Policy # _____Group # _____

Subscribers Name _____Relationship to Patient_____

Subscriber's Date of Birth_____Subscriber's Social Security #_____

Secondary Insurance_____

Policy Holder's Name _____ Relationship to Patient _____

Contract # _____ Group # _____

Subscriber's Date of Birth _____ Subscriber's Social Security #_____

Husband's Employer & Phone # _____

Please initial: I consent to have my picture taken for my medical record _____

I authorize the release of any medical information necessary to process insurance claims for payment to All About Women OBGYN **I understand that if I am not eligible under the terms of my medical and hospital health insurance, I am liable for all charges for services rendered and I agree to pay all costs associated with my account if placed for collection**. Accounts are considered delinquent and will be placed for collection if not paid in full within 90 days of date of service.

SIGNATURE_____

Please sign acknowledgement: "Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice provided pursuant to Florida law."

SIGNATURE_____

PLEASE SIGN NEXT PAGE

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by All About Women OBGYN, or disclosed to others for the purpose of treatment, or obtaining payment to support operations of the practice.

Notice of Privacy Practices
You should review the **Notice of Privacy Practices** for a more complete description of how your protected health information may be used or disclosed and it is available on request.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use of disclosure of your protected health information.

All About Women OBGYN may or may not agree to restrict the use or disclosure of your protected health information.

If All About Women OBGYN agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
All About Women OBGYN reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and give my permission to All About Women OBGYN to use and disclose my health information in accordance with the **Notice of Privacy Practices**.

PLEASE LIST ANY PERSON(S) YOU WOULD LIKE TO RELEASE YOUR MEDICAL INFORMATION

NAME_____ **RELATION**_____

NAME_____ **RELATION**_____

NAME_____ **RELATION**_____

_____
NAME OF PATIENT (PRINT)

_____
SIGNATURE OF PATIENT **DATE**

*****A PARENT/PATIENT REPRESENTATIVE IS NEEDED ONLY IF THE PATIENT IS A MINOR, NOT PHYSICALLY ABLE OR MENTALLY COMPETENT TO SIGN FOR THEMSELVES*****

_____
SIGNATURE OF PARENT/PATIENT REPRESENTATIVE **DATE**

_____
PARENT/RELATIONSHIP OF PATIENT REPRESENTATIVE