

**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.**  
**Charlie N. Kelly, ARNP-BC**

Date \_\_\_\_\_

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** \_\_\_\_\_

# **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 or 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