CINCINNATI Breast Surgeons

cintibreastsurgeons.com

New Patient Registration and Consent Form

Patient Information:

Last Name: _____ **First Name**: _____ **Today's Date**: _____

Other/Maiden Name: _____ **Preferred Name**: _____

Date of Birth: _____ **Soc. Sec. No.** _____

Address: _____ **City, State, Zip**: _____

Cell Phone: _____ **Other Phone:** _____

Email: _____
(By providing your email, you will be receiving communications regarding our patient portal and care center services)

Preferred Communication (Mark all that apply):
(By marking cell phone, you agree to receive text messages with appointment related reminders and information.)
□ Cell Phone □ Other Phone □ Email

Is it okay to leave a brief message with medical information and/or appointment reminders to your preferred method of communication? □ Yes □ No

Birth Sex: □ Male □ Female

Gender Identity: □ Male □ Female □ Genderqueer/neither exclusively male nor female
□ Transgender Female-to-Male (FTM) □ Transgender Male-to-Female (MTF)
□ Other, please specify: _____ □ Prefer not to answer or decline
Our team believes that all individuals deserve access to quality care, regardless of their gender self-determination. It Is Important for us to understand, both clinically and socially, the sex and gender of our patients in order to provide the best experience possible.

Sexual Orientation: □ Straight or heterosexual □ Lesbian, gay, or homosexual □ Bisexual □ Don't know
□ Something else, please specify: _____ □ Prefer not to answer or decline

Preferred Pronoun: □ She/Her □ He/Him □ They/Them □ Other

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated □ Domestic Partner

Spouse/Domestic Partner Name: _____

Preferred language: □ English □ Spanish Other_____

Interpreter/Translator needed: □ Spanish □ American Sign Language Other _____

Race: □ American Indian or Alaska Native □ Native Hawaiian or Other Pacific Islander □ Asian

□ Black or African American □ White □ Prefer not to answer or decline

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Prefer not to answer or decline

Employment Information

Employment/Student Status: □ Full-Time □ Part-Time □ Not Employed □ Self-Employed □ Active Military

□ Retired □ Full-Time Student □ Part-Time Student

Employer: _____

Occupation: _____ **Phone:** _____

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Minor Information (under 18 and not emancipated)

Parent/Legal Guardian Name: _____ **Phone:** _____

Relationship: □ Parent □ Grandparent □ Other Relative □ Other _____

Emergency Contact

Name: _____ **Phone:** _____

Relationship: □ Spouse/Partner □ Parent □ Child □ Other Relative □ Friend □ Other

Primary Care Provider/Referring Provider

Primary Care Physician: _____ **Phone:** _____

Address: _____

Referring Physician (if different): _____ **Phone:** _____

Address: _____

Pharmacy Information

Local Pharmacy Name: _____ **Phone**: _____

Address: _____ **City, State, Zip**: _____

Mail In Pharmacy Name: _____

Insurance Information

Primary Insurance Provider: _____

Policy Holder Name: _____ **Policy Holder DOB:** _____

Policy Holder Employer: _____

Secondary Insurance Provider: _____

Policy Holder Name: _____ **Policy Holder DOB:** _____

Policy Holder Employer: _____

Additional Information

How did you hear about our practice? Please check all that apply:

□ Advertisement-Print or Magazine
□ Advertisement-Billboard
□ Advertisement-Online
□ Community Event
□ Insurance Directory
□ Referral from friend or relative
□ Internet Search
□ Social Media
□ Website
□ Signage/Drive-by
□ Referral from a provider

GENERAL CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

Thank you for choosing Axia Women's Health. We appreciate your confidence in us and are committed to providing you with the highest quality of care. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like more detailed explanations of financial policies, please request a copy.

General Consent to Treat: I, the undersigned, authorize Axia Women's Health, its agents, associates, as well as physicians and advanced practice providers to provide medical and surgical services. This includes but is not limited to examination, treatment, and performance of diagnostic tests or procedures, which are necessary for the diagnosis and treatment of medical conditions according to the judgment of the treating provider.

Financial Responsibility and Assignment of Benefits: By signing below, I understand and acknowledge that:

- I am financially responsible for the medical care provided to the patient.
- It is my responsibility to provide my accurate active insurance information at every appointment.
- It is my responsibility to know in-network providers, coverage, benefits, and any additional requirements for the patient's insurance policy.
- Charges not covered by the patient's insurance, as well as applicable co-pays, co-insurance, deductibles, and any charges denied due to incorrect insurance information are my responsibility.
- I am financially responsible for medical services regardless of any divorce decree or court order. This includes services rendered to minors who may be covered by another parent's insurance under a custody agreement.
- I hereby assign all medical and surgical benefits, including major medical benefits which I am entitled, including Medicare, and I am authorizing benefits to be paid directly to Regional Women's Health Group, LLC (Pennsylvania and New Jersey) or Seven Hills OB-GYN Associates, LLC (Indiana, Ohio, and Kentucky) also known as Axia Women's Health. I authorize the release of any pertinent medical information necessary to facilitate payment of my claim(s).
- My insurance policy is a contract between me and the insurance company. Claims submission by Axia is performed as a courtesy. Axia will not become involved in disputes with my insurance carrier.
- I am ultimately responsible for the timely payment of any services rendered.
- I understand I may incur, and am responsible for, the payment of additional charges not covered by insurance. These charges may include (but are not limited to)
    - Non-sufficient check/closed account fees;
    - Collection costs if my account is forwarded to collections;
    - Charges for copying and distributing of patient medical records;
    - Fees for form completion;
    - Fees for missed appointments without proper notice.

Co-pays and balances: I understand co-payments and balances are due at the time of check in **PRIOR** to being seen by the provider and are payable by cash, check, and most major credit cards.

Missed appointments: I understand I am expected to provide at least 24-hour notice in advance for all cancellations. Missed appointments without proper cancellation notices may be subject to a fee assessed to my account and I may be discharged from the practice. I understand I should make every effort to keep my appointment to promote my medical well-being.

Good Faith Estimate for Non-Emergent Services: I understand that upon my request, health care practitioners must provide a good faith estimate of the total price they will charge for a non-emergency health care service that has been ordered, scheduled or referred. I will not be charged for this information. In addition, the estimates are not binding, the final price may vary from the estimate based on patient's medical needs, and the estimate is valid for 30 days.

Referral Notification: In the event my provider refers me to another provider/specialist, I acknowledge it is my responsibility to verify network coverage with my insurance carrier. I understand that this is not verified by Axia Women's Health and I am responsible for any charges accessed.

Patient Name_____ Date of Birth_____

Acknowledgement of Notice of Privacy Practices: I understand that Axia is required by law to maintain the privacy of protected health information and provide individuals with notice of their legal duties and privacy practices and the patient's rights with respect to protected health information. I acknowledge that I have been given the option of receiving and/or reviewing the Axia Women's Health Notice of Privacy Practices. If I have any questions, I understand I can speak with the Privacy Officer.

Health Information Exchange ("HIE"): A HIE allows doctors, nurses, pharmacists, other health care providers to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care. I understand and agree that Axia may share, store and/or transmit my PHI, including sensitive information related to HIV, sexually transmitted diseases, mental health, drug and alcohol treatment, genetic testing, and reproductive health, electronically to a health information exchange. If I am receiving treatment from another health care provider, that provider may be able to access all my PHI from a health information exchange. I consent to such access and disclosure.

If I wish to opt out of sharing my data via HIE, I understand I must download and complete the Opt-Out Form located on the Axia Women's Health website under the Notice of Privacy Practices section or contact the Privacy Officer at privacy@axiawh.com to be provided with the Opt-Out Form to be completed and returned.

Photo/Face ID images: I agree that any copies of photo identification made or photography of my face taken by Axia will be considered a part of my medical record and will be used solely for the purposes of identification.

Chaperone: I understand Axia may use a chaperone during breast, pelvic, and rectal exams. Additional time will be allotted for private conversation with my provider.

Friends and Family involved in care (Optional)
I give permission for the following individuals to receive information about my treatment and payment to assist in my healthcare. I understand this permission is valid until revoked.

□ Same as my emergency contact listed above

Name: _____ **Phone:** _____

Relationship: □ Spouse/Partner □ Parent □ Child □ Other Relative □ Friend □ Other

Name: _____ **Phone:** _____

Relationship: □ Spouse/Partner □ Parent □ Child □ Other Relative □ Friend □ Other

By signing below, I acknowledge I have read, understand, and agree to the above regarding Authorization for Treatment, Payment and Healthcare operations.

_____

Patient/Authorized Signature **Date**

TELEMEDICINE CONSENT

Introduction: Telemedicine involves the use of live two-way audio and video electronic communications between patient and provider to provide healthcare services. This can be performed via smartphone, tablet, or computer with camera and microphone and reliable internet/data services.
Electronic communications will be performed through a third-party software system that includes security safeguards to protect the confidentiality of your information.

Expected Benefits:

- Improved access to medical care that may enable a patient to remain at home and consult with or receive treatment by a physician or other healthcare provider from their office.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

There are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- Equipment, connection problems or information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by your healthcare provider(s) which may delay your care;
- Lack of hands-on exam may make it hard for the provider to diagnosis your problem;
- A lack of access to complete medical records may interfere with your provider's medical judgement and negatively impact your care;
- There may be limitations on what my provider can prescribe to me without an in-office visit (e.g. controlled substances);
- Security safeguards could fail, causing a breach of privacy of your information.

By signing this form, I understand the following:

1. Potential risks and limitations of this mode of treatment (including, but not limited to, the absence of in-person examination) and agree to be treated in a remote fashion.
2. All laws about the privacy of my health information and medical records apply to telemedicine.
3. I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I can chose to receive care in person.
4. I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information.
5. I will be notified of all parties involved during telemedicine visit.
6. It is up to me to make sure the setting for my session is private and only includes people who I am willing to share health information with.
7. I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I should contact my provider's office for follow-up care, worsening conditions or any other problems.
9. I have been able to ask questions about telemedicine and all of my questions have been answered.

_____

Patient/Authorized Signature **Date**

Patient Name_____ Date of Birth_____