FOR WOMEN HEALTH CARE

Ayodele Olowookere, M.D., P.A.
Obstetrics & Gynecology

Name:	Age:	Sex: M F	Birth Date:
Street Address:	City:	Zip:	SS#
Mailing Address:	City:		Zip:
Home / Cell Phone:	Email Address:		
Employer:	Address:		Work Phone:
Email Address:	Occupation:		Referred By:

Race/Ethnicity:
☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Latino ☐ Multi-Racial ☐ Native American ☐ Pacific Islander ☐ Other (please specify) _____

SPOUSE OR LEGAL GUARDIAN

Name:	Legal Guardian: Yes No		Birth Date:
Street Address:	City:		Zip:
Home/Cell Phone: Work Phone:	Email Address:		SS#
Employer:	Address:		Email Address:

In Case of Emergency (Friend or Relative not listed above ONE MUST BE LOCAL)

Name (1):	Address:	
Home & Cell Phone:	Work Phone:	Relation:
Name (2):	Address:	
Home & Cell Phone:	Work Phone:	Relation:

List any immediate Family Member(s) Already Under the Dr's Care

Name:	Name:	Relation:

Pharmacy Information

Pharmacy Name:	Phone Number:	Pharmacy Address:

INSURANCE INFORMATION (A copy of ALL insurance cards is required for filing purposes)

Primary Insurance:		Name of Insuree & SS#:
Group #:	Insuree's DOB:	Insurance ID#
Secondary Insurance:		Name of Insured & SS#:
Group #:	Insuree's DOB:	Other Insurances (cont on back):
Medicare? Yes or No	Medicare #	SS#

How did you year about us? Radio Web Mailers Events Newspaper

How would you like us to communicate with you? Home Phone Cell Phone Work Phone Email

Your receipt for each visit will contain all the information needed to process an insurance claim. Please remember that insurance is a method of reimbursing you for fees paid to the doctor and is not a substitute for payment.

All charges payable at time of service unless prior credit arranged

I hereby assign to For Women Healthcare all payments for medical services rendered to my myself or my dependents. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plans to For Women Healthcare. This assignment will remain effective until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I hereby authorize For Women Healthcare to release any pertinent medical information to my insurance carries for myself or my dependents

DATE

SIGNATURE OF PATIENT (or Parent/Legal Guardian if Patient is a minor)

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Authorization Form For Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below.

Patient Name: _____ Date of Birth: _____

The health information you may release subject to this authorization is as follows:

_____

_____

Release my protected health information to the following person(s) entity:

Name: _____ Relation _____ Name: _____ Relation _____

Street: _____ Street: _____

City: _____ State: ____ Zip: _____ City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____ Phone: _____ DOB: _____

The reasons or purposes for this release of information are as follows:

_____

_____

_____

This authorization shall be in force and effective until the following event and/or date: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:

Privacy Officer: Enny Olowookere
For Women Healthcare
2110 W. Michigan Ave
Midland, TX 79701

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy of policy itself.

I understand that information used or disclosed pursuant to this authorization may be to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. **The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.**

_____ _____

Signature of Patient Signature of Personal Representative

_____ _____

Date Description of Personal Representative's Authority

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AUTHORIZATION FOR MEDICAL RECORDS

I hereby authorize Medical Records concerning:

Patient's Name _____

Current Address _____

City _____ State _____ Zip Code _____

Date of Birth _____ Social Security Number _____

To be released from:

Physicians Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Please send to:

Ayodele Olowookere, M.D., P.A.
Obstetrics & Gynecology
2110 W. Michigan Ave.
Midland, TX 79701 Phone (432) 688-8888 Fax (432) 653-4136

I understand that disclosure will be made for and will be limited to the following specific types of information for treatment rendered to me during the period from ____ to ____.

_____ Medical History & Physical _____ Operative Reports

_____ Lab & X-ray Reports _____ All Records

_____ Treatment & Progress Notes _____ (Other) Please List

_____

_____

_____

I understand that this consent is subject to revocation by me at any time except to the extent that action has been taken in reliance hereon. If not revoked, it shall terminate 90 days from date signed without express revocation.

_____

Patient Name Signature Date

PLEASE FAX OR SEND AS SOON AS POSSIBLE. THANK YOU!

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgment and Consent

This acknowledgment of notice and consent authorizes **FOR WOMEN HEALTHCARE** to use and disclose health information for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. **FOR WOMEN HEALTHCARE** has a Notice of Privacy Practices and to make the terms of any change effective for all protected health information and how you can access your protected health information. And exercise other rights concerning your protected health information. You may review notice by submitting a written request to our Privacy Officer.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any changes effective for all protected health information that we maintain, including information created or obtained prior to the date of the effect date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Consent to Treatment. I voluntarily consent to receive medical and health care services provided by **FOR WOMEN HEALTHCARE**, employees and such associates, assistants, and other health care providers. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only.

I acknowledge that **FOR WOMEN HEALTH CARE** may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, Treatments, prescriptions. Please mark if you agree to accept artificial messages by:

Phone Calls Yes No **Text Messages** Yes No **Emails** Yes No

How to contact our Privacy Officer: **FOR WOMEN HEALTHCARE** 2110 W. Michigan Ave. Midland, TX 79701. Attention Privacy Officer. Telephone: (432) 688-8888. FAX: (432) 653-4136

Acknowledgment and Consent

I have received the Notice of Privacy Practices for **FOR WOMEN HEALTHCARE** physicians. **FOR WOMEN HEALTHCARE** is authorized to use and disclose health information about patient listed below for treatment, payment and health care operations purpose consistent with its Notice of Privacy Practice.

_____ _____

Signature of patient
(or patient's personal representative)

Date

_____ _____

Name of Personal Representative

Relationship to patient (or other authority)

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CONSENT FOR TREATMENT

I hereby authorize evaluation and treatment to For Women Healthcare. I understand and agree that the signatures on this form will not expire without written notice or in the case that a minor becomes an adult, and that a photocopy or scanned image of this form is considered valid as the original.

Patient or Legal Guardian Signature

Date

Ph. (432) 688-8888

2110 W. Michigan Ave.
Midland, TX 79701

(432) 789-1433