Wellstar Cobb Gynecologists

Patient Demographics:

Name: _____SSN:_____

Sex:_____ Birth Date:_____ Email address: _____

Street Address:_____Apt:_____

City:_____ State:_____ Zip Code: _____

Employer:_____Full/Part Time:_____

Patient Contact Information:

Home #_____ Cell #_____

Work #_____ Emergency Contact:_____

Emergency #_____ Emergency Contact relation:_____

General information:

Marital Status:_____ Religion:_____

Primary Care Dr:_____

Insurance Demographics: (If same as patient "skip" this section)

Policy Holder's Name:_____ Relationship:_____

Policy Holders SSN#:_____ Policy Holders Date of Birth:_____

Policy Holders Address:_____

Employed by:_____ Full/Part Time:_____

Secondary Insurance Information (if applicable)

Policy Holders Name:_____Relationship:_____
Policy Holders SSN#:_____Policy Holders Date of Birth:_____
Policy Holders Address:_____
Employed by:_____ Full /Part Time:_____

WELLSTAR Health System

Patient Communication Designation

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service. The provision of this information is optional.

Patient Information *(please print clearly):*

Last Name *First Name* *Middle Initial* *Date of Birth (Month / Day / Year)*

Street Address *Apt. # / P.O. Box # (Please include complete mailing address)* *Medical Record # / Social Security # (optional)*

City *State* *Zip Code* *Primary Contact Number*

If we cannot reach you at the telephone number listed above, WellStar may contact you (including leaving messages) regarding appointments or **normal** lab results at the following number(s):

Business Number *Cell Phone Number* *Other Phone Number*

I authorize WellStar Health System to disclose Protected Health Information to the following persons:

☐ Spouse: _____
Name *Phone Number*

☐ Child(ren): _____
Name *Phone Number*

_____
Name *Phone Number*

☐ Other: _____
Name *Phone Number*

Information to be disclosed:

☐ All Medical Information ☐ Laboratory Results ☐ All Billing / Account Information

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the WellStar location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that WellStar cannot require me to sign this authorization as a condition of treatment unless the provision of health care by WellStar is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.*

Signature / Date:

(date authorization signed by patient or Legal Guardian / Personal Representative) _____
Month / Day / Year

Print Patient Name or Name of Legal Guardian / Personal Representative ***Signature of Patient or Legal Guardian / Personal Representative***

Indicate relationship to patient (required)

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.*

WELLSTAR.
Medical Group

Acknowledgment of Receipt
"NOTICE OF PRIVACY PRACTICES"

I acknowledge that I have received a copy of WellStar Health System's ***"Notice of Privacy Practices"*** for protected health information on the date set forth below.

Date of Receipt

Patient Date of Birth

Print Patient Name

Print Name of Authorized Personal Representative

Patient Signature

Signature of Authorized Personal Representative

Please indicate relationship to patient

FOR USE BY WELLSTAR HEALTH SYSTEM PERSONNEL ONLY
(complete if patient acknowledgement is not obtained)

An Acknowledgment of Receipt of Notice of Privacy Practices was not received because:

- ☐ Patient refused to sign Acknowledgment
- ☐ Unable to gain signed Acknowledgment due to communication / language or other barrier
- ☐ Patient was unable to sign Acknowledgment due to emergency treatment situation
- ☐ Other (*please indicate reason*): _____

Signature of WellStar Representative

Date

WellStar Medical Group

Acknowledgment of Receipt of Notice of Privacy Practices

WELLSTAR.
Medical Group

Dear Valued Patient:

Thank you for selecting the WellStar Medical Group. We are honored that you have chosen us as your health care provider. Our goal is to provide you and all of our patients with the highest-quality, individualized medical care in a timely and respectful manner.

Our commitment to our patients is that we will do our best to provide same-day access for sick visits and will make every attempt to see you at your appointment time for routine scheduled appointments. Last minute cancellations and not arriving on time for appointments are an inconvenience that affects other patients who are scheduled to be seen that day. We have developed a WellStar Medical Group policy regarding no-shows and late cancellations in order to help us meet our goal. Having such a policy enables us to better utilize available appointments for all of our patients in need of medical care.

Cancellation of an Appointment

If you are unable to keep your appointment, please call your WMG healthcare provider's office promptly, so that this time can be reallocated to someone who is equally in need of care. If you must cancel your scheduled appointment, we require that you call at least 24 hours in advance if you are seeing a primary care physician (Internal Medicine, Family Practice, Pediatrics or ObGyn) or at least 48 hours in advance if you are seeing a specialist. Appointments are in high demand, and your early cancellation will give another person access to that appointment time. A **late cancellation** is when a patient fails to cancel his or her scheduled appointment with 24-hours advance notice for primary care or 48-hours notice for specialty care.

How to Cancel Your Appointment

To cancel appointments, please call your WMG healthcare provider's office, or utilize MyChart's "Appointments – Cancel an Appt" function.

Missed Appointment or "No-Show"

A **no-show** is someone who misses an appointment without cancelling it at least 24 hours in advance for a primary care visit or at least 48 hours for a specialty visit. Failure to be present at the time of a scheduled appointment, or arriving 15 minutes or more after your scheduled appointment, will be recorded as a no-show. Patients may be subject to dismissal from the practice on the third occurrence of a missed appointment or no-show, or a combination of either.

Again, we appreciate you placing your trust in the WellStar Medical Group for your healthcare needs.

Sincerely,

WellStar Medical Group