Form Instructions

1. Please complete the forms below
2. Please save and email to: WomensCare@suddenlinkmail.com or print and fax to: (318) 352-9818
3. If you have any questions or problems filling out the forms you may reach us at: (318) 352-9595

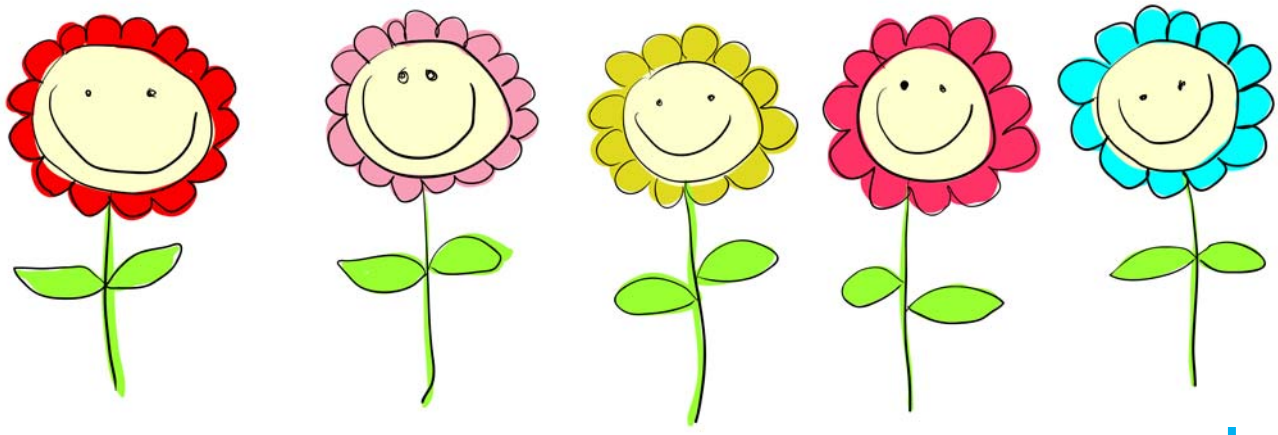
Scroll down to view the forms below

Natchitoches Women's Care

Martin Aviles, MD FACOG – Kelli Porter, WHNP BC – Jualeah Early, CNM
Obstetrics and Gynecology

PLEASE PRINT AND COMPLETE ALL ENTRIES					
Patient's Name (Last, First MI)		Date of Birth	Age	Marital Status	Today's Date 1/19/10
Patient's Address (**Street**)		**Patient's Home Phone**		**Patient's Work Phone**	
Your Employer's Name: Your Occupation:		**Patient's SSN**		**Patient's Cell Phone #**	
Employer's Address (Street)		Patient's Drivers License # State Issued:		Who referred you to us? Why?	
Spouse's Name (Last, First, MI)	Spouse's DOB	Spouse's SSN		Spouse's Work Phone	
Your Email Address	May we contact you by Email? ☐ Yes ☐ No	What is your maiden name?		Your previous Address	
Nearest relative (not) living with you	Address (Street – City – State – Zip)			Home Phone	
Emergency Contact - -	Relationship			Phone - -	
Who is financially responsible for your bill? *(Required to be completed):*					
Why are you being seen today? *(Required to be completed):*					
INSURANCE INFORMATION					
Primary Insurance:	Are you the policy holder? ☐ Yes ☐ No			Secondary Insurance: [Patient->Secondary Insurance % Patient]	
If you are on your parent's or other's insurance policy please give the policy holder's information below: **Policy Holder's Name:** **DOB: / /** **SSN: - -** **Policy Holder's Home Phone:** **Work Phone: - -** **Policy Holder's Full Address:** **City:_____ St:_____ Zip:_____**					

All co-pays, co-insurance and any charges meeting the unmet portion of your deductible are due today. We do not offer installment plans.



SNEAK PEEK

CATCH A GLIMPSE OF YOUR
BABY LIKE NEVER
SEEN BEFORE.

AVAILABLE AT THE INITIAL
OB VISIT ONLY!!

(MUST BE LESS THAN
20 WEEKS PREGNANT)

FOR $50.00 YOU WILL RECEIVE
TWO PICTURES OF YOUR BABY
IN 3D/4D REAL TIME IMAGING.

Promoting women's health and wellness through all stages of life.
627 Bienville Circle, Natchitoches, LA 71457 – www.NatchitochesWomensCare.com
Phone: 318.352.9595 – Fax: 318.352.9818 – WomensCare@suddenlinkmail.com [Default->Login Title]

PHI AUTHORIZATION

All the personnel of Natchitoches women's Care take your medical confidentiality very seriously. We will not and cannot release any of your information without yoru written authorization.

This authorization form, when completed and signed, allows our staff to speak only with an individual or individuals you designate in the event that you are not available to receive our phone calls or you have an adult family member that helps coordinate yoru medical care or bills. You should not designate a physician.

If you feel, for example, comfortable allowing us to talk with another person regarding an appointment, you should check that box. Please check all the boxes that apply to the designated person you choose. If there are two persons you wish to authorize, please complete the next section on both.

I, [Patient->Full Name] authorize the employees of Ntchitoches Women's Care to speak with:

Contact Name:
Relation to Patient:
Phone:

CHECK ALL THAT APPLY

- ☐ APPOINTMENTS
- ☐ LAB RESULTS
- ☐ TEST RESULTS
- ☐ MEDICAL CARE
- ☐ BILLS

Contact Name:
Relation to Patient:
Contact Name:

CHECK ALL THAT APPLY

- ☐ APPOINTMENTS
- ☐ LAB RESULTS
- ☐ TEST RESULTS
- ☐ MEDICAL CARE
- ☐ BILLS

***If you are on your parent's or other's insurance policy, we have the right to discuss your insurance plan information (ONLY) with the policy holder if needed. Your treatment will not be discussed with them unless you have authorized for us to do so.**

Information regarding any of the above may also be left on my:
☐ Answering Machine ☐ Voicemail ☐ Email
My e-mail address is: [Patient->Email]

☐ **I do not authorize anyone to receive information regarding my medical care.**

_____ _____
Patient Signature Date

This PHI consent expires ____/____/____ or never.

PRIVACY POLICY ACKNOWLEDGEMENT

I, _____, have receive a copy of the Natchitoches Women's Care Notice of Privacy Policy on / / .

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GYNECOLOGIC HISTORY

If you feel uncomfortable answering any questions: Leave blank and discuss you're your doctor or nurse.	
First day of last normal menstrual period?	
Age periods began?	
Length of periods? (Number of days bleeding)	
Number of days between periods?	
Number of sexual partners?	
Sexual partners are men, women or both?	
Present method of birth control:	
Have you ever used Intrauterine Device (IUD) or birth control pills?	
If yes, for how long?	
When was your last Pap Test?	
What was the result?	
Have you ever had an Abnormal Pap Test?	
Do you do regular Breast Self-Examination?	
How did you know about us:	

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FINANCIAL POLICY

I understand that I am responsible for payment in full for any and all services rendered to the patient by the medical office of Martin Aviles, M.D. regardless of any insurance benefits payable or pending. I further understand that it is the policy of this medical practice that payment in full is due at time of service with the following exceptions:

1. **Medicare** patients do not have to pay at the time of service but are fully responsible for co-insurance and deductibles after Medicare pays.

2. **Medicaid** patients are responsible for any charge not covered by Medicaid including non-covered office and hospital visits/procedures of any kind. The Medicaid patient is also solely responsible for getting any necessary referrals from their Community Care Providers when this applies to them

3. **Private insurance** groups (State of LA, Group Benefits, EPO, PPO, Ochsner's, MultiPlan, and any other group, PPO or HMO) we participate in are only responsible for their co-pay or percentage pay at time of service (deductibles, co-insurance, or co-payments). If you have any other insurance you are responsible for payment in full at time of service.

This does not carry accounts. Any uncollected accounts are turned over to the Alexandria Credit Bureau. Also, any NSF check will be turned over to the *Natchitoches District Attorney's* office and the patient will be responsible for an additional NSF fee of $25.00.

I HAVE READ THE ABOVE STATEMENT AND ACCEPT SERVICES ON THE TERMS AS STATE ABOVE.

Date _____ Patient or Guardian Signature _____