Cassie HEALTH CENTER FOR WOMEN

1618 E. Pine Street, Silver City, NM 88061
Phone: (575) 388-1561
1 (888)388-1562 Toll Free
Fax: (575) 388-9952

Welcome to Cassie Health Center for Women (CHCW). We are pleased that you have selected us for your healthcare. The following information will help you receive the best care and services.

Office Hours: Monday – Thursday: 8:00 a.m. to 5:00 p.m. Friday: 8:00 a.m. to 3:00 p.m.

Scheduling Appointments: Patients are encouraged to meet all providers at Cassie Health Center for Women: Victor A. Nwachuku, MD is an Obstetrician/Gynecologist. Michelle Diaz, MD is an Obstetrician/Gynecologist. Gail Stamler is a Certified Nurse-Midwife. They provide care to the obstetric and gynecologic patients sharing the on-call schedule for after-hour needs and deliveries. There is always a physician available to provide back-up services for Ms. Stamler, if such services are needed. Please talk to the providers if you have questions about how to schedule your appointments. Unless you have been told otherwise, you can make your appointment with the provider of your choice. Please keep in mind that keeping your appointment is very important. We recommend that you are here at least five (5) minutes prior to your scheduled appointment. When you know you cannot make your appointment, please call us immediately to cancel or re-schedule. If you are fifteen (15) minutes late, we may have to re-schedule your appointment for another day.

Ultrasounds: We have a certified ultrasound technician, Marti Egnaczak, (RDMS) is a Registered Diagnostic Medical Sonographer. She is here Monday, Tuesday, and Wednesday.

After-Hours Care: Cassie Health Center for Women offers 24-hour availability for its patients. If you have a concern that arises after clinic hours, please call the clinic phone number to access the after-hour call services. Your call will be directed to the provider on call.

Lab Results: It may take up to 2 weeks to receive lab results, and at times, it may take longer. For normal results, a letter will be sent to you. For abnormal results, a phone call will be made to you as soon as possible. Please contact our office if you have not received notification within 1 month of your test.

Medication Refills: Please call your pharmacy ***at least 1 week prior to running out of your medication***. Your pharmacy will send us a refill request. Keep in mind that it may take up to 72 hours to send the request back to your pharmacy. If your prescription is a controlled substance, please let us know so that we may contact your pharmacy for you.

Rooming Patients: Patients may be called before you due to a variety of reasons and might be seeing a different provider than you. Please do not get upset when this happens. We have not forgotten you. We will call your name as soon as your provider is ready for you. Everyone will be treated with the utmost respect in this clinic.

Visit our website at www.cassiehealthcenter.com

PATIENT INFORMATION

Name _____ SS# _____-_____-_____

Mailing Address _____ DOB _____/_____/_____

City, State, & Zip _____

Home Ph(_____)_____ Mobile Ph(_____)_____Work Ph(_____)_____

Primary Ph ____Home ____Mobile ____Work
(Best Number to Reach You)

□ Single □ Married □ Divorced

Employer _____ Phone (_____)_____

Mailing Address _____City, State, & Zip _____

Parent/Guardian Name(if patient is a minor)_____

Relationship to patient_____

Mailing Address _____City, State, & Zip _____

SS # _____-_____-_____ DOB _____/_____/_____ Phone # (_____)_____

Employer _____Occupation _____Phone # (_____)_____

Primary Insurance _____ Secondary Insurance _____

Policy Holder Name _____ Policy Holder Name _____

Policy Holder DOB _____/_____/_____ Policy Holder DOB _____/_____/_____

Policy Holder Social Security #_____-____-_____ Policy Holder Social Security #_____-____-_____

Relationship to Patient _____ Relationship to Patient _____

Subscriber ID # _____ Subscriber ID # _____

Group # _____ Group # _____

Do you have a power of attorney? _____ yes _____ no If yes, we need a copy of the legal document.

Do you have a legal guardian? _____ yes _____ no If yes, we need a copy of the legal document.

OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service. Your understanding of our financial policy is an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our staff.

INSURANCE

CHCW does not participate with all insurance plans. It is my responsibility to know if CHCW is a participating provider with my insurance company. CHCW will file a claim on my behalf to my insurance carrier. CHCW will collect any co-payment, co-insurance, and/or deductible at the time of service. **If I do not have my insurance card, co-payment and/or deductible at the time of service, CHCW may re-schedule my appointment for another day**. In the event my insurance denies a claim for any reason, I am responsible for the complete charge. Payment will be due upon receipt of statement.

_____ Initials

It is also my responsibility to call my insurance for confirmation of coverage for my office visit and/or procedure.

_____ Initials

My insurance policy is a contract between me and the insurance company and not CHCW. CHCW will do their best to work with my insurance carrier, but I am ultimately responsible for all charges incurred.

_____ Initials

SELF-PAY

As a self-pay patient I am required to pay at least half of the office visit cost. A payment plan can be set up with the billing department for the remaining balance. A 20% discount will be applied when the balance is over $100.00 and paid in full on the same date of service.

_____Initials

Failure to adhere to our financial policy can result in dismissal from the practice and delinquent account information will be reported to our collection agency. All cost incurred for collections will be charged directly to you.

SLIDING FEE

We now offer a sliding fee scale for patients who do not have insurance. Based on household income you can qualify for a discount on your visits with us **provided we receive the necessary documents required**. Applications are available at the front desk.

EMERGENCY CONTACT

Name _____

Address _____

_____

Phone Number _____

Cell Number _____

Relationship _____

PHARMACY INFORMATION

Name of Pharmacy_____

City_____

Telephone Number_____

HIPAA NOTICE OF PRIVACY PRACTICE

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. You may reference the document posted for details. Please ask the front office for the location.

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practice.

AUTHORIZATION FOR RELEASE OF PRESCRIPTION HISTORY

I grant permission for Cassie Health Center for Women to obtain all prescription history from external sources as needed.

INSURANCE AUTHORIZATION

I hereby authorize Cassie Health Center for Women to furnish information to my insurance carrier(s) concerning my illness and treatments. I hereby assign the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not paid by my insurance. The Guarantor (must be over 18 years of age), is responsible for payment(s) for all services rendered to minor patients.

I have read and understand the financial policy of the practice and I agree to be bound by its terms.

INSURANCE COVERAGE

I understand the service(s) that is being performed today **may not be covered** for payment by my insurance. If I, or my dependant choose to receive this service(s), I agree to be responsible for paying the financial charges for this service(s).

It is understood that I will be responsible for all charges incurred on this account which will include all present and future services. I understand that regardless of the insurance coverage that I may have, I am responsible for paying all charges. In the event of non-payment of charges for the services rendered, I agree to pay all cost of collections including reasonable attorney's fees. I hereby authorize Cassie Health Center for Women to release any information occurred in the course of my examination or treatment. I also certify that payment be made to Cassie Health Center for Women for services rendered.

_____ _____

Print Name Signature

_____

Date

Cassie Health Center for Women is required by law to furnish information to other Physicians, Attorneys, Insurances, etc.

Authorization For Release of Information

This authorization and password is **required** for you and any of your family members, friends, etc., to have access to your appointments, test results, and/or financial status, etc. **Without this password, no information will be given to you.**

DOB: _____

I _____, authorize Cassie Health Center for Women to release
(Print Name)
information, medically and/or financially to the following person(s):

_____	_____
Name	Relation
_____	_____
Name	Relation

My password is: _____

I understand that Cassie Health Center for Women will release information only to the name(s) listed above. I also understand that I am responsible for updating or revoking this form as necessary, **in person and in writing.**

_____	_____
Signature of Patient or Representative	Date