Woman's CLINIC
A Professional Association
Obstetrics/Gynecology

NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services we provide you. We will not disclose your record to others, unless you direct us to do so or unless the law authorizes or compels us to do so. You may get more information by contacting our Medical Records Department or Privacy Officer.

X SIGNATURE _____ DATE _____

AUTHORIZATION TO SHARE HEALTHCARE INFORMATION I permit you to share my healthcare information with

Name:_____ or FAX#_____ Relationship: _____

(please check all that apply)

☐ my healthcare information with exception to pregnancy testing, prenatal care, contraception and STD testing

☐ all information to include pregnancy testing, prenatal care, contraception and STD testing

☐ only information relating to _____

This authorization ends only upon my written request.

X SIGNATURE _____ DATE _____

FINANCIAL POLICY

Our office is committed to providing quality and cost-effective healthcare to our patients. It is essential that you understand what services are covered by your insurance plan and obtain all authorizations prior to your appointment. Your doctor may recommend services he/she feels are beneficial but may not be covered by insurance. It is your responsibility to understand the limit and restrictions affecting coverage for these services. ***If your insurance company requires you to use a specific lab, it is your responsibility to notify us of this.*** Insurance reimbursement is a contract between you and your insurance company. As a courtesy to you we file all claims for you. We will require a current copy of your insurance card in order to do this and will need to be informed of all changes in insurance status. You will be responsible for all co-pays, deductibles, co-insurance amounts along with the entire amount of any non-covered services. Payment for services is expected at the time of service. Patients who do not have insurance coverage (or proof of coverage) or who choose to pay for non-covered services are expected to pay in full at the time of service. If you cannot pay the full amount then you must make satisfactory payment arrangements with our business office **prior** to receiving services.

X SIGNATURE _____ DATE _____

(Please be advised that this will serve as acknowledgement that you understand Tenncare is not routinely accepted by the Woman's Clinic, P.A. However, you understand that you may ask about an exception to this policy through the Woman's Clinic insurance department and agree to adhere to the qualification guidelines.)

X SIGNATURE _____ DATE _____

PREVENTATIVE CARE SERVICES

Your health plan may not provide benefits for preventative services. It is important you determine if your plan offers benefits for this service and their guidelines for it. We use industry standard codes and guidelines to submit insurance claims based on the encounter and documentation in the medical record. Current laws regarding fraud/abuse with billing procedures prohibit us from changing the procedure and/or diagnosis codes in order to get the claim paid by the insurance company.

X SIGNATURE _____ DATE _____

INSURANCE/BILLING INFORMATION

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release any information required to obtain reimbursement. I agree that I am financially responsible for all service provided and should it be necessary to refer the account to a collection business associate, I will be responsible for all fees including but not limited to collection fees, attorney fees, and court costs involved with my account.

X SIGNATURE _____ DATE _____

NO SHOW POLICY (eff. 1-1-2014)

I am aware that if I fail to appear for scheduled appointments (and fail to cancel appointments) twice within a 6 month time-frame, my account will be assessed a $25 fee for which I will be responsible for paying prior to scheduling another appointment. The Woman's Clinic hopes that this policy, in addition to the reminder service in place, will help to encourage our patients to cancel or reschedule any appointments they are unable to keep.

X SIGNATURE _____ DATE _____

Permission to View Medication History: ❑ **Yes** ❑ **No**