General Consent

Consent to Medical Care and Treatment: I consent to all medical and surgical care, examinations and tests which are determined to be necessary for me while I am a patient of Women Physicians in OB-GYN, Inc. I understand that the practice of medicine and surgery is not an exact science and that medical treatment may involve risks, injury or even death. I acknowledge that no guarantees have been made to me as to the results of any treatment, procedure, or examinations to be performed on me while I am a patient at Women Physicians in OB-GYN, Inc.

Refusal of Treatment: I understand that if I refuse treatment that is suggested for me or I do not complete a treatment protocol recommended to me, I will not hold Women Physicians in OB-GYN, Inc. nor any individual responsible for the consequences of my refusal or incompletion. Refusal of treatment and failure to complete treatment protocol will result in termination of your relationship with Women Physicians in OB-GYN, Inc. and its physicians.

Release of Information: I authorize Women Physicians in OB-GYN, Inc. to disclose copies of all or any part of my medical records obtained in the course of my diagnosis and treatment to any insurance carrier, workers compensation carrier, welfare agency, or any other entity, which may be providing financial assistance for my medical care. I understand that this disclosure may include information concerning Human Immunodeficiency Virus (HIV) testing, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related condition(s), psychiatric condition(s) and/or alcoholism or drug abuse. I also authorize the release of medical information for utilization and quality assurance review to my insurers or their subcontractors and as required by any city, state, or federal laws or third party payer agreements. I authorize Women Physicians in OB-GYN, Inc. to disclose medical information to my family physician, referring physician or any other provider directly involved in my medical care. I hereby give my express consent to Women Physicians in OB-GYN, Inc. and its agents to contact me at any phone number (including my cellular phone number) that I have given to Women Physicians in OB-GYN, Inc. personnel for a legal purpose related to my care and any other recommended follow up or future care, by means including the use of either automatic telephone dialing systems or other computer-assisted technology. This consent is subject to written revocation by the patient or without revocation will expire one year from this date.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me or the patient named below, I hereby assign to Women Physicians in OB-GYN, Inc. all right, title, and interest in and to any third-party benefits due from any and all insurance policies employee benefit plans and/or responsible third-party payers in an amount not to exceed Women Physicians in OB-GYN, Inc.'s regular and customary charges for the medical care and treatment rendered. I authorize such payments from my insurance carriers, third-party payers and any other third-parties. I consent to any request for review or appeal by Women Physicians in OB-GYN, Inc. to challenge a determination of benefits made by a third-party payer, insurance carrier or employee benefit plan. Except as required by law, I assume responsibility for determining in advance whether the services provided to me are covered by my insurance or other third-party payer.

Financial Responsibility: Subject to applicable law and the terms and conditions of any applicable contract between Women Physicians in OB-GYN, Inc. and a third-party payer, and in consideration of all health care services rendered or about to be rendered to the patient named below, I agree to be financially responsible and obligated to pay Women Physicians in OB-GYN, Inc. for its total charges not paid under the "Assignment of Benefits" made above. Any balance due for any medical care and treatment I receive from Women Physicians in OB-GYN, Inc. must be paid in accordance with Women Physicians in OB-GYN, Inc.'s Financial Policy. All balances must be paid within thirty (30) days after receipt of a statement. I understand that I will be responsible for the costs of any services rendered to me that are not eligible for benefits under Medicare, Medicaid, insurance or other payers. Failure to abide by Women Physicians in OB-GYN, Inc.'s Financial Policy will result in termination of your relationship with Women Physicians in OB-GYN, Inc. and its physicians.

Statement to Permit Payment of Medical Benefits to Provider and Physician(s): I certify that the information given by me in applying for payment under Medicare or Medicaid is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its contractors any information need for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf directly to Women Physicians in OB-GYN, Inc. and its physicians providing medical care and treatment to me.

Tobacco-Free Information: Tobacco use of any kind is not allowed inside or outside Women Physicians in OB-GYN, Inc.'s facilities. Compliance with Women Physicians in OB-GYN, Inc.'s tobacco-free policy is expected of all patients and visitors.

Privacy Notice: I have been offered a copy of Women Physicians in OB-GYN, Inc.'s Notice of Privacy Practices and Financial Policy within the past year.

Personal Valuables: Women Physicians in OB-GYN, Inc.is not responsible for any lost, stolen, or damaged personal Items.

Nondiscrimination Statement: In providing medical care and treatment, Women Physicians in OB-GYN, Inc. compiles with all applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, ethnicity, religion, culture, language, age, disability, socioeconomic status, sex, sexual orientation, gender identity or expression or any other classes protected by such laws.

Acknowledgment

By signing below I hereby acknowledge that I have read and understand this General Consent and that t have been given the opportunity to ask questions and receive clarification so that I can fully understand and agree lo this General Consent.

WOMEN PHYSICIANS IN OB-GYN, INC. - FINANCIAL POLICY

Thank you for choosing us as your women's health care provider. We are committed to providing you with the best possible medical care. Please understand that payment of your bill is considered part of your treatment and the following information is provided to avoid any misunderstanding or disagreement concerning payment for services provided by our office.

1. Please understand that if you have insurance, your health insurance company should adjudicate the bill for your health care services. They may apply some of those costs to your deductible, coinsurance and/or copay. They may determine that some services are not covered under your benefit plan. It is your responsibility to pay such amounts.
    a. If we are not contracted with your insurance plan, you will be responsible for any additional financial amounts ("out-of-network" patient responsibility).
    b. If you do not have health insurance for the date of service, you are responsible for payment for all services rendered on that date.
    c. If a charge is paid by you, then later covered/paid to us by your insurance company, you will be reimbursed. If you do not have insurance coverage or are insured by a company with which we are not contracted, payment in full is expected at the time of service.
2. By your written consent, you authorize Women Physicians in OB-GYN to release all necessary information in accordance with HIPAA privacy guidelines, to determine eligibility and payment liability, secure payment, and to obtain reimbursement to the extent necessary. You assign benefits for all medical, surgical, and/or other major medical health care coverage to which you are entitled, including private insurance and other health plans to Women Physicians in OBGYN, Inc. This assignment will remain in effect until you revoke the assignment in writing.
3. If your insurance policy requires you to have a referral from your primary care provider prior to seeing our provider, it is your responsibility to obtain that referral prior to your visit. Otherwise, you may choose to receive care from our providers at your own expense. In such cases, payment will be expected at the time of service.
4. Our office participates with a variety of insurance plans. It is your responsibility to:
    a. Bring your current insurance card to every visit and notify us of changes in coverage when you check in.
    b. Pay your co-pay and/or outstanding balances at the time of service. Payment can be made by cash, check, MasterCard, Visa, Discover or American Express.
5. Patients who are being seen for physical exams and require additional treatment for illnesses or services may be charged separately for each service, even though both services are provided on the same day. Yearly well woman exams may or may not be covered under your health insurance policy; however, they may be required by your physician. Some forms will not be completed and signed if physicals are not up to date.
6. This office can only code and file a claim for a patient's visit with a diagnosis that was encountered and documented in the medical record. To request a diagnosis change solely for the purpose of securing reimbursement from the insurance carrier is inappropriate and could be considered a fraudulent act.

7. Women Physicians in OB-GYN reserves the right to charge you a fee for any appointment you do not show up for and/or do not reschedule/cancel within 1 business day of your scheduled appointment. Frequent and consistent no show, canceled, and/or rescheduled appointments may result in your being dismissed from the practice.
8. You will be charged $25.00 for all returned checks. There is a fee to copy any or all medical records, as well as a fee for completing any form required by an outside entity. This includes, but is not limited to FMLA, BWC, Disability, and/or other treatment related forms.
9. If you have a high out-of-pocket expense for deductibles, copays, and/or co-insurances, you will be required to make a down payment prior to services rendered. We will work with you to arrange payment plans upon request.
10. Your physician may order services to be performed outside of our office including lab services. You are responsible for checking with your insurance company to determine if that facility is covered by your insurance, what the benefits are for the services, and if there are necessary prior authorizations required. Our billing representative will assist you with any procedure code or diagnosis code you may need to provide to your insurance company in order to obtain coverage/eligibility information.

Thank you for reviewing our financial policy. By signing the acknowledgement, you certify that you reviewed, understand, and have had the opportunity to ask questions regarding our financial policy. You also certify that you will abide by all information within this policy and accept financial responsibility for all services provided by Women Physicians In OB-GYN, Inc.

Acknowledging General Consent and Financial Policy:

Patient Name (printed): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Signature of Patient's Authorized Representative: _____ Date: _____

Witness Signature: _____