The Center for Women's Health

PRIVACY & BILLING PROCEDURES
AUTHORIZATION & ACKNOWLEDGEMENT

This authorization, acknowledgement and waiver cover all services rendered to the assigned patient for today and all futures dates of service. You may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any events that occurred before you notified us of your decision to revoke.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Privacy of your medical information is of the utmost importance. A Health Insurance Portability and Accountability Act (HIPAA) office policy is in place. A copy is available to you on the patient portal and can also be requested at the time of your office visit. This policy discloses how your information is used, disclosed, and accessed.

The Center for Women's Health reserves the right to modify the privacy practices outlined in the Notice of Privacy Practices. I have had the opportunity to read or have received a copy of the Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law. We may not release any information to anyone, including your spouse, without your written specific request.

AUTHORIZATION TO TREAT & BILL

I give consent and authorization to The Center for Women's Health to examine and provide all routine medical care, diagnostic procedures, disposing of any specimens or tissue taken from my body, and provide treatment which provide in the judgment of the medical provider, may be necessary or beneficial to my health and wellbeing with no guarantees expressed regarding the results of examination and treatment by aforementioned facility.

I authorize the release of any medical and demographic information necessary to process all claims. I authorize payment of medical benefits to The Center for Women's Health for all services performed.

I understand that I am responsible for all charges incurred at the time of service unless other arrangements were made prior to being treated. I will pay any deductible, co-payment, co-insurance, and any amounts denied or not covered by insurance. I understand it is my responsibility to check with my insurance carrier prior to my visit for covered and non-covered benefits and whether or not The Center for Women's Health visit will be paid with my in-network or out-of-network benefits billed as office place of service (POS 11).

I understand that if I do not provide complete and accurate billing/Insurance information at the time of service and this lack of information prevents The Center for Women's Health from collecting from my insurance company, I will be responsible for the full charges. If a referral or additional forms are required by my insurance company, I understand I am responsible for providing The Center for Women's Health with a referral within 48 hours of my visit and/or complete all insurance required forms in a timely manner, or I may be responsible for all charges.

Collection Fees: If payment is not made as agreed upon, the account will be turned over for collection. The patient, and/or guarantor, shall be responsible for and agree to pay all reasonable cost of collection including, but not limited to, reasonable collection agency fees, attorney's fees, and court costs.

Jurisdiction and Venue: If any suit must be filed to collect an unpaid balance on an account, patient, and/or guarantor, agrees that such suit may be brought in courts of Wicomico County, Maryland, and waives any objection to jurisdiction or venue.

Assignment & Release: I hereby request and assign directly to The Center for Women's Health all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, including collection fees and/or interest that may accrue, whether or not paid by insurance. I hereby authorize the Provider to release all information necessary to secure the payment of benefits unless written notice is given to revoke this authorization. I authorize the use of a copy of this signature is as valid as the original signature on all of my insurance submissions. Co-pays and/Self Pay fees are due at the time of service. All account balances will be the patient's and/or guarantor's responsibility after processing of insurance. Full balance is due within 15 days or upon receipt of the first invoice and, if applicable, may be assessed a $15.00 delinquent account fee after 90 days invoice.
*** CFWH does not participate with any Medical Assistance at this time.**

►PLEASE SIGN HERE:
PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE: _____
DATE:_____

OUTSIDE LABORATORY, RADIOLOGISTS & ANESTHESIOLOGISTS

It is my understanding that The Center for Women's Health may send lab specimens to an outside laboratory or have an anesthesiologist present for procedures they provide to you at our facility. I give permission for those outside laboratories and Anesthesiologist to bill my insurance for their services. I understand that I may incur additional charges as a result of those outside laboratory tests and Anesthesiologist. I understand that The Center for Women's Health is not responsible for payment to those laboratories and/or Anesthesiologists.

►PLEASE SIGN HERE:
PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE: _____
DATE:_____

NON-COVERED SERVICES

It is my understanding that my insurance company may deem my visit to The Center for Women's Health as a non-covered service and may make me fully responsible for payment of all charges for these services. I also acknowledge that I am aware that The Center for Women's Health **does not** participate with any Medical Assistance.

►PLEASE SIGN HERE:
PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE: _____
DATE:_____

ABOUT OUR PHYSICIANS AND SERVICES

I have received, read and understand Center for Women's Health Policies and Practices and agree to the terms mentioned within.

►PLEASE SIGN HERE:
PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE: _____
DATE:_____