Patient Consent to the Use, Disclosure and Request of Health Information for Treatment, Payment, or Health care Operations and Acknowledgement of the Opportunity to Read and/or Receive the Health Information Privacy Practices

Patient Name: _____

As part of your health care, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals who contribute to your care
- Submit your diagnosis and treatment information for payment from insurance companies or others

By signing this document, and *"only as permitted by State or Federal law"*, you are giving this practice your consent to do the following:

- To disclose, as may be necessary, your health information to other health care providers (such as, referrals to or consultation with, other health care professionals, laboratories, hospitals, etc.) for your treatment and/or health care
- To request from other health care entities (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific health care information we may need for planning your care and treatment.
- To submit your diagnosis and treatment information to insurance company(s), other agencies and/or individual(s) for payment of services
- Leave appointment reminders or information, we believe necessary for treatment or payment, with a family member or on an answering machine, the information will be the minimum necessary in our professional judgment
- Discuss your health information (only as necessary in our judgment) with family members or other persons who are or may be involved with your health care treatment or payments
- Please list by name and relationship any person with whom we may not share your health or payment information (based on professional judgment, this practice has the right not to honor your request) _____

We will make available to you our *"Notice of Patient Privacy Practices"* that provides a more complete description of health information uses and disclosures as required by the HIPAA standard. You have the following rights:

- The right to read the *"Patient Health Information Privacy Practices"* prior to signing this consent
- The right to request a copy of the *"Patient Health Information Privacy Practices"* for your own personal use

I fully understand and agree to this consent and acknowledge the above rights and disclosures.

_____	_____	_____
Signature	Print name of person signing	Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes [ ] No [ ] RELATIONSHIP _____. If you are not the parent, please provide a copy of your legal authority for this patient.

FOR OFFICE USE ONLY

[ ] "Consent form" reviewed by (employee) _____ on (date) _____

[ ] Patient refused to sign the consent form. Reason for patient refusal to sign _____

[ ] Restrictions added by the patient (see restrictions listed above)

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ACKNOWLEDGMENT OF POLICIES

Name of Patient:_____ Patient's DOB:_____

Parent/Guardian:_____

PLEASE READ, INITIAL AND SIGN

Labs

_____ You have been advised by the health care provider that as a result of your appointment today, they will need to send lab work to an outside lab for interpretation, (ex: pap smear, biopsy, etc), If the labs ordered are not covered by your insurance, you will receive a separate bill for any/or all tests that were ordered by the provider.

Pharmacy

____ It is your responsibility to provide our office with your preferred pharmacy name and phone number. Please make sure that you provided the correct information to the front desk and or nurse.

Returned Check Charge:

___ If we receive a returned check from your bank due to non-sufficient funds, closed account, etc. you will be charged an administrative fee of $35.00. Future services will require payment by cash, money order, or credit/debit card.

Co-Pays/co-insurance/deductibles

_____ Co-pays, co-insurance/deductibles are due at the time of service. Patients will be asked to reschedule their appointment if the appropriate funds are not collected.

Completion of Forms:

____There is a $25.00 charge per form for the completion of all paperwork, including FMLA, short term and long term disability forms. Payment will be collected at the time the paperwork is received in our office. Paperwork will be completed as quickly as possible (up to 2 weeks). Our office will contact you when it is completed.

I have read, understand and acknowledge I have received the financial policy.

Signature of Patient or Guardian _____**Date:**_____

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Diplomates of the American Board of Obstetrics & Gynecology

M. Joanne Bevers, C.N.M., M.S.N.
Therese E. Goode, P.A.-C.
Jill S. Miller, ARNP

Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

_____

Parent, Patient's Signature or Authorized Representative Date Time

_____

Relationship to Patient Interpreter, if utilized

_____

Witness Signature

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LABORATORY TESTING

Attention All Patients:

It has been advised by your health care provider that as a result of your appointment today, we will be sending lab work to an outside lab for interpretation. If the labs ordered are subject to your deductible, co-pay, co-insurance, and in some cases not covered by insurance you will receive a separate lab bill for any/or all tests that were ordered by the practitioner.

We currently send all in house specimen collections to LabCorp of America. If they are not contracted with your insurance they will forward to correct Lab facility.

All outside lab orders will be submitted to the lab of your choice.
Please specify as to which lab to send orders for outside of office testing to:

- _____LabCorp of America
- _____Quest Diagnostics
- _____Other
  (Please specify name of other lab)_____

If your insurance is not contracted with any of the above labs please advise the nurse **PRIOR to seeing the practitioner.**

It is the **patient's responsibility** to know what laboratory your insurance is contracted with, please check your provider directory for the participating laboratory on your plan. Please be advised if you choose to have your labs drawn at any other facility or doctor office there may be a delay in our office receiving the results.

_____ _____
Print Patient Name Date of Birth

_____ _____
Patient Signature Date

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