Center For Women's Health
4840 College Blvd
Overland Park, Kansas 66211

Patient Name:_____HIPAA CONSENT Chart Number:_____

In accordance with patient confidentiality and privacy laws, we will need your written permission to discuss appointments, test results, medical records, prescriptions and your account information with anyone other than yourself. Please ***LIST BELOW ANYONE*** you give permission to access your information (**including billing/account balance information**) by phone, fax or mail.

- ○ No one (I understand this includes spouse/doctors/etc)
- ○ Spouse/Children_____
- ○ Other_____

I understand that I have the right to revoke this authority at anytime, but I must do so in writing. The revocation does not apply to any information already released.

_____ _____ _____
Signature of Patient or Legal Guardian/Parent Relationship Date

I hereby acknowledge that I have been offered a copy of Center for Women's Health **Notice of Privacy Practice.**

Initial_____ **Date**_____

CONSENT TO CORRESPOND ELECTRONICALLY

While Center for Women's Health takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

I acknowledge if I use electronic mail to initiate contact with Center for Women's Health regarding my medical care, the physician and/or his representatives have my permission to correspond via that email address.

I give permission for Center for Women's Health physician and/or staff members to email me at _____@_____ regarding my medical care.

AUTHORIZATION FOR TREATMENT

I hereby authorize medical treatment for myself or my dependent as deemed necessary by the providers of Center for Women's Health.

PHARMACY BENEFIT MANAGEMENT CONSENT

In order to ensure we have the most accurate and up-to-date information on your medication, we are able to import all of your current medications directly from your pharmacy(s) into our Electronic Health Records via a SECURE connection. We will continue to verify your medications, but importing them electronically saves you and our staff time. By providing us with your signature below, you are authorizing us to import your medications on your behalf. I hereby authorize Center for Women's Health to import my medications from my pharmacy(s) into their electronic health record.

By signing this consent form you are agreeing that Center for Women's Health can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

AUTHORIZATION/ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, Private, HMO/PPO, and commercial insurances as well as third party payors be made on my behalf to Center for Women's Health for any services furnished to me or my family by Center for Women's Health. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment or for determination of benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original. In addition.

_____ _____ _____ _____
Signature of Patient or Legal Guardian/Parent Relationship Date Center for Women's Health Representative Signature (verified)

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FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill for services rendered. Any balances, co-pay and/or deductibles are due prior to seeing the physician. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. You also understand you are responsible for any amount not covered by your insurance. In the event your insurance company requests a refund of the payment made, you will be responsible for the entire charge amount. Our office makes no guarantee of benefits. **Any quoted benefits provided by your insurance company are considered general overview and only a guideline until payment is received. All services are subject to review by the insurance company once a claim is received and they determine if a payment will be made.**

A parent who brings a minor child to our office for medical care is legally responsible for payment of all charges.

If you do not have insurance, payment is expected when services are rendered. If payment in full is not possible at the time services are rendered, payment arrangements may be made in advance. You must notify the office prior to your appointment if you are unable to pay in full.

I understand and agree that if I fail to make payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, interest, and attorney fees.

I understand if I am unable to make a scheduled appointment, I must cancel within 24 hours of my appointment time. I understand if appointments are repeatedly missed, Center for Women's Health may be forced to dismiss me from the practice.

Center for Women's Health accepts payments in the form of Credit Card (Discover, Visa and MasterCard) or cash. We do not accept checks.

CREDIT CARD ON FILE POLICY

At Center for Women's Health, we require keeping your credit or debit card on file as a method of payment for the portion of services your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. **I understand it is my responsibility to always keep an active credit or debit card on file in order to stay compliant with the financial policy. Failure to do so, may result in dismissal from the practice.**

I authorize Center for Women's Health to charge the portion of my bill that is my financial responsibility to the following credit or debit card:
☐ Visa ☐ Mastercard ☐ Discover
Credit Card Number _____
Expiration Date _____ / _____ / _____
Cardholder Name _____
Signature _____
Billing Address _____
City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Center for Women's Health to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.
This authorization relates to all payments not covered by my insurance company for services provided to me or my dependents by Center for Women's Health. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give notification to Center for Women's Health in writing and the account must be in good standing.

Patient Name (Print): _____
Patient Signature: _____
Date: _____ / _____ / _____

I have read the above information. I UNDERSTAND MY RESPONSIBILITIES FOR THE PAYMENT OF MY ACCOUNT.

_____	_____	_____	_____
Signature of Patient or Legal Guardian/Parent	Relationship	Date	Center for Women's Health Representative Signature (verified)