Patient Acknowledgment of Privacy Practices

(HIPAA)

I have been advised of the Notice of Privacy Practices at LaGrange Women's Health. I also understand that if I wish to receive copies of this Notice of Privacy Practices or if I have any questions with regard to this Notice of Privacy Practices, I may contact the receptionist or write a letter to:

Chief Privacy Officer/Compliance
1602 Vernon Road, Suite 200
LaGrange, GA 30240

Patient Signature: ____________________________________ Date: ____________________

Authorization of Release of Information and Benefit Payments

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information necessary to process insurance claims. I also authorize the release of any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby assign and authorize payment to LaGrange Women's Health of all medical/surgery benefits including major medical benefits to which I am entitled to under any insurance policies, self-insurance program, or under any benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for any medical fees or charges incurred by myself or anyone on my behalf. I accept responsibility including but not limited to payment of those fees and charges not directly reimbursed to LaGrange Women's Health by any insurance policy, self insured program or other benefit plan. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Patient/Policy Holder Signature: ______________________ Date: ___________________