

Patient acknowledgement 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 a copy 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 mail in my request to:

Chief Privacy Officer/Compliance

1602 Vernon Road, Suite 200

Lagrange, GA 30240

Patient Signature: _____ Date: _____

Authorization of Release of Information and Benefit Payment

I hereby authorize the release of my 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/surgical 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 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: _____

Insurance/Important patient information

Our office, like all others are seeing major changes in healthcare services that are covered by insurance companies. To assure that your needs are met, we are asking that you check with your insurance carrier to determine if:

- Your insurance covers annual preventative pap and pelvic annual examinations.
- Your insurance covers laboratory test that may be performed outside of our office.

Medicare covers an annual screening pap smear examination every 2 years. Your annual exam will be coded as preventative care. Medicare may consider this as a “non-covered” service. If so, you will be responsible for the office visit.

I understand that I am responsible for any balance that my insurance company does NOT cover.

Patient Signature: _____ Date: _____

Office Policies/Procedures

Our office hours are Monday – Friday from 8am until 5pm.

It is necessary that we work by appointment only. Sometimes emergencies, surgeries and deliveries do occur which can occasionally put a delay in our schedule or cause some appointments to be rescheduled. We will do our best to honor your appointment time.

If you arrive 10 minutes late to your appointment, you will be seen as a work in appointment which may cause an extended waiting period. If you arrive 15 minutes late, we will reschedule your appointment for another more convenient day.

As a courtesy, we file your office visits with your insurance company. All copayments, deductibles and other services NOT covered by your insurance company are your responsibility. You should be prepared to pay these amounts at the time of service.

As a courtesy to our doctors and nurses, we ask that you turn off your cell phone during your visit and examination.

I have read and understand the office policies.

Patient Signature: _____ Date: _____