

CONSENT TO TREAT

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates and assistants of the physician's choice. Our office follows the standards of care recommended by the American College of Obstetricians and Gynecologists (ACOG) and the Center for Disease Control (CDC).

Initials

HIPAA AUTHORIZATION / RED FLAG POLICY

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates and assistants of the physician's choice. For further explanation or for a copy of our HIPAA Privacy Notice and/or Red Flag Policy please see the front desk staff or visit our website. *This release is effective until revoked by patient with written signature.*

Please mark appropriate section below:

____ No Restrictions ____ Restrictions: (Please list your requested restrictions)

If there is anyone you would allow us to share information with, please list the names and relationships of those people below.

____ **May share my protected health information with:**

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Initials

FINANCIAL POLICY

Welcome to *Obstetrics and Gynecology Care Associates, S.C.* The following outlines the patient financial responsibility policy. Payment for services provided by *OB/GYN Care* is required at the time of services unless prior arrangements have been made. **Co-pays, co-insurance, deductibles, and/or non-covered services are due at the time of service, no exceptions.** Our office participates with many major insurance companies. If we are contracted with your insurance company, we will bill your insurance company as a courtesy to you. Understand that it is ultimately your responsibility as the patient to know your insurance coverage. We encourage every patient to know their medical benefits, if you need further clarification contact your insurance company directly. Please be aware that benefits quoted *OB/GYN Care* is not a guarantee of benefits and/or payment. Co-Insurance and allowable information given to *OB/GYN Care* is an estimate and further payment may be required after your claim has been paid. Exact payment is not determined until your claim is processed by your insurance company.

Initials

If you need a major medical service (such as having a baby or needing surgery), we will help you estimate the cost of your medical services. A financial agreement form will be completed which should include the cost of the surgery, any deductible due, an estimate of your insurance payment and an estimate of the amount that you will need to pay for the service. Financial arrangements can be discussed in advance so that a specific payment plan can be arranged, if necessary. All fees are required to be paid in full prior to delivery or surgery.

Initials

You will receive a statement showing in detail charges incurred during the statement period and the amount due. Any uncollected fees are **payable within 15 days** of receiving the statement. You are responsible for complete payment of any charges that you incur whether covered by your insurance or not covered by your insurance. A finance charge of **2%** per month or **24%** annually will be incurred 31 days following the date the services were provided. If your account becomes delinquent and referred to a collection agency, you will be responsible for the costs of collection and/or legal fees. All accounts that are 90 days past due will automatically be assigned to a collection agency, regardless of insurance coverage. Accounts assigned to collections will include a **35%** collection and processing fee and will not be allowed to schedule future appointments.

Initials

There will be a **\$25.00 cancellation fee** for all appointments not canceled within 24 hours of the appointment. A fee of **\$50.00** for all surgical appointments not canceled within 24 hours of appointment. A **\$35.00** fee will be charged for all returned checks or stop payments.

Initials

I authorize *OB/GYN Care Associates, S.C.* to release to my insurance carrier and its agents any information needed to determine the benefits payable under their coverage. I further authorize my insurance company and its carriers to disclose any information requested regarding claims for medical benefits to *OB/GYN Care Associates, S.C.* A copy of this authorization may be used in place of the original.

Initials

I request that payment of authorized medical benefits be made on my behalf to *OB/GYN Care Associates, S.C.* for services furnished to me, any physician covering the patients of *OB/GYN Care Associates, S.C.* or the staff of *OB/GYN Care Associates, S.C.* unless I have paid for the services and will be billing the insurance company directly.

Initials

Your signature below indicates that you understand and agree to the above.

Signature of Patient: _____ **Date:** _____

Signature of Parent/Legal Guardian: _____

We look forward to providing you with the highest quality care and trust. We hope you will find us friendly and helpful. You may receive a patient satisfaction survey and we would appreciate it, if you could take a few minutes to let us know how we are doing. You may also visit our website and complete a survey online.