ADVANCED WOMEN'S HEALTH SPECIALISTS

www.advancedwomens.com

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT

I, _____, have received a copy of the notice of Privacy Practices from Advanced Women's Health Specialists.
(Patient's Name)

Date: _____ Patient's Signature _____

Insurance Signatures
(Please check all that apply and sign below)

☐ **For Medicare Patients:** I request that payment of authorized Medicare benefits be made either to me on behalf, or to Advanced Women's Health Specialists for any services furnished. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents, any information needed to determine these benefits payable for related services. I also authorize the payment for authorized Medigap benefits are made on my behalf to Advanced Women's Health Specialists for services provided. I authorize any holder of medical information about me to release to the Medigap insurer listed above any information needed to determine these benefits, I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim because my signing this authorization will cause Medicare payment information to cross over automatically.

☐ **Non-Medicare Patients:** I authorize release of any medical information necessary to process this claim and related claims. I request that payment of authorized benefits be made either to me or on my behalf to the physician for any services furnished to me by that physician.

☐ **Medicaid Recipient Disclaimer:** I understand that in the event I become Medicaid ineligible, transfer to an Advanced Women's Health Specialist's non-participation Medicaid Health Maintenance Organization or see Medical care for GYN related services, I will be fully responsible for all incurred charges.

☐ **All Patients:** I agree to pay all charges for myself or for members of my family, as applicable, promptly upon presentation therefore. Charges as shown by statements are agreed to be correct unless protested in writing within thirty days. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon. In the event that legal action should because necessary to collect an unpaid balance due, I am in full agreement to pay all attorney's fees and other such costs as the Court determines proper. I am in full agreement that I will be charged a collection fee of 35% of the total amount on my account in the event it has to be placed in a collection agency.

☐ **Consent for treatment of Minor:** The undersigned hereby consents to the provisions of examinations, treatments, medical and laboratory procedures, drugs and supplies to the patient, as ordered or requested by the patient's physician(s), and acknowledges that no guarantee or assurance has been made as the results of such treatments, procedures, and examinations.

_____ _____

Parent or Guardian Signature Date

☐ **Well Women Exam:** Please be advised, I, the undersigned, am aware that I am here for a well women exam and understand that I my insurance does not cover well women exams, I am responsible for payment in full. Advanced Women's Health Specialists cannot re-file this claim with a change in diagnosis code in attempt to be reimbursed. Please understand that if you are an HMO patient with a medical problem and you are here for your well women exam, you must also have a referral/authorization to be treated for a problem.

_____ _____

Parent or Guardian Signature Date

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