WEST END Obstetrics & Gynecology, PC

Date:

PATIENT FINANCIAL RESPONSIBILITY FORM

THANK YOU FOR SELECTING WEST END OB/ GYN FOR YOUR WOMEN'S HEALTH CARE NEEDS. WE ARE HONORED BY YOUR CHOICE AND ARE DEDICATED, COMMITTED AND UNDERSTANDING OF YOUR MEDICAL CARE NEEDS. WE ASK THAT YOU READ AND SIGN THIS FORM TO ACKNOWLEDGE YOUR UNDERSTANDING OF YOUR FINANCIAL OBLIGATIONS AND OUR FINANCIAL POLICIES.

It is your responsibility:

- **To present** your insurance card at **every visit**. You are required to provide us with **the correct and updated information** about your insurance, address, and contact information. You will be responsible for any charges incurred if the information provided is not correct. ***Maternity patients need to contact us Immediately if there is a change in your insurance any time during your obstetrical care***.
- **Of knowing what services are covered and not covered under your plan** along with authorization requirements, referrals, your deductible, co-insurance, and copays. If you are not familiar with your plan, **we recommend you contact your insurance carrier before services are rendered.**
- **To have your copay or deductible payment at each visit**. Payment can be made by cash, check, Visa, MasterCard, Discover and American Express or Care Credit. **For self-pay patients**, you will need to speak with our Practice Manager before your visit and **payment is required before services will be rendered**.
- **To pay** any remaining balance in full within 30 days after our receipt of your insurance payment. WEOB will bill your insurance as a courtesy, however; all charges, regardless of insurance coverage are **your responsibility**.

Annual / Routine Paps/ Problem Visits

- We send our pathology to outside labs for processing. You may receive a separate bill from the laboratory or pathologist's office. These providers **may or may not** participate with your health plan.
- If you are seen for a routine/annual visit and ***ANY*** illness or problem is addressed, proper coding will be used which may result in ***a charge for both services*** likely making you responsible for at the least a copay.

Non-Covered Service Policy

Unfortunately, not all services are paid by the insurance company. You may be financially responsible for any of the following services:

- o Infertility
- o Skin Tags
- o Contraception
- o Surgery
- o Ultrasound
- o Procedures
- o Routine Services
- o Maternity
- o Problem Visits

The estimated cost for the office visit to evaluate any of the above diagnoses is $100 - $300.
I understand the cost of the office visit relating to any of the above diagnoses and agree to be fully responsible if my insurance does not cover the cost. If your account becomes delinquent, it may be referred to a collection agency. A 28% late payment fee will be assessed in addition to attorney fees and/ or court costs that may be incurred in an attempt to collect the debt.

By signing below, you authorize payment directly to West End OB/GYN. You agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms. This document is valid for 1 year from the date signed.

Patient Name (Please Print):_____

Patient Signature: _____Date:_____

Responsible Party Name (Please Print):_____

Responsible Party Signature: _____Date:_____

Authorization to Disclose Health Information to Family Members and Friend

I_____ Date of Birth_____/_____/_____ hereby authorize West End Obstetrics & Gynecology, PC (WEOBGYN) to release my patient health information as described below:

NAME	RELATIONSHIP	Type of Info to Disclose (Check all that apply)		Method of Disclosure (Check all that apply)	
		Medical	Billing	Phone	In Person

Person Protected Health Information ("PHI") may include information/documents regarding medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing. I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions, the right to revoke and a description of how I may revoke this Authorization is set forth in WEOBGYN's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature; and that I should send it to the attention of the "HIPAA Compliance Officer". I understand that I am not required to sign this Authorization and that WEOBGYN's may not condition treatment on my execution of this Authorization. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA**. This authorization expires when I am no longer a patient in this practice or I have revoked this authorization.**

(Check One) I DO____DO NOT____ GIVE PERMISSION to West End Obstetrics & Gynecology, PC, to leave information on my answering machine and/or with my family members in regard to treatment plans, referrals, test results and/or billing and payment information. HIPAA guidelines allow for basic information regarding appointments (time, date, location) to be left on an answering machine or with family members. HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of WEOBGYN. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization, If you choose not to authorize any family members or friends for disclosure of PHI, WEOBGYN will not be able to release any information patient billing questions to anyone other than the patient.

_____ _____

Signature of Patient or Guardian Relationship of Guardian to Patient

Printed Name of Patient/Guardian_____ Date of Authorization_____

WRITTEN ACKNOWLEGEMENT FORM

Our notice of privacy practices provides information about how we may use and disclose medical information about you. As provided on our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I_____(patients name) have been provided a copy of the Medical Practice's Notice of Privacy Practices.

I have had the opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the Practice Administrator if I do not understand any information contained in the Notice of Privacy Practices.

_____ _____ _____

Patient Signature or Guardian Signature Patients DOB Date

_____ _____

Patient or Guardian Name Print (Guardian Relationship to Patient)