NOTICE OF PATIENT'S PRIVACY AND INDIVIDUAL RIGHTS

- Is it o.k. that we call you (whether it is to remind you of an appointment, your insurance, test results, or for any other reason necessary)? YES NO

Please provide current day time phone number: ____________________

- Is it o.k. that we leave messages on your answering machine or voicemail? YES NO

- Are you aware of what HIPPA means to you? If no, please see the receptionist and ask for a copy of our patient privacy practice sheet. YES NO

- Is there anyone that you give us permission to discuss your health-related information? YES NO

If yes, please list, and their relation to you:

1)_________________________________ 3)_______________________________

2)_________________________________ 4)_______________________________

FINANCIAL POLICY

- If you do not have insurance, you must pay for your visit in full.
- If you do have insurance and we are a participating provider, we will file it for you.
- If we have filed your insurance twice, and they have not paid, you will be responsible for payment.
- There is a $35 fee for returned checks and redepositing a check.
- Anything that your insurance does not cover or denies, you will be responsible for.
- The parent and/or guardian bringing a minor patient in is responsible for making the payment that is due on the patient's account.
- Please give a 24 hour notice if you need to cancel or reschedule an appointment. Canceled appointments less than 24 hours and missed appointments will be subject to a $25 fee. A second missed appointment will be subject to a $50 fee and a third missed appointment will result in dismissal from this practice.

I HAVE READ AND UNDERSTAND THE PATIENT PRIVACY ACT, THE FINANCIAL POLICY AND NOTICE OF PRIVACY PRACTICES OF WOMEN'S HEALTH ASSOCIATES. I CONSENT TO MEDICAL TREATMENT AND UNDERSTAND THAT THIS AGREEMENT IS IN EFFECT FOR ONE YEAR UNLESS REVOKED IN WRITING BY MYSELF.

___________________________________ ________________

Signature of Patient or Guardian Date

_________________________________________

Printed Name of Patient or Guardian

Be Your Best