

Consent for Treatment

AN ANNUAL VISIT IS YOUR WELL WOMAN VISIT. A PROBLEM VISIT IS A PROBLEM, NOT YOUR ANNUAL VISIT.

Insurance issues, requirements and coverage are ever changing, and we are making every effort to eliminate payment denials. Please keep in mind, if an annual visit is scheduled and a problem is discovered during your exam or if you present a problem/complaint during your annual visit, by contract, both services must be appropriately documented in your medical records and billed for. Depending on the coverage you have, you may be responsible for a portion of the billed amount at the time of service. We cannot change the coding (fraud) to ensure that your insurance company will pay for a non-covered service.

General Consent for Treatment:

“Knowing that I am seeking preventative care and/or suffering from a condition requiring diagnostic, medical or surgical treatment do voluntarily consent to such procedures, care and to such medical, surgical or other services under the general and specific instruction of Dr. Maryann Prewitt at Health Care for Women, PA her assistants, or her designee as is necessary in her judgment. I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examination by Dr. Maryann Prewitt or associates for Health Care for Women, PA,” – Texas Medical Association.

I agree that should I not receive the results of tests within 2 weeks upon their completion, it is my obligation to call the office and inform them of this. I also understand that if Dr. Prewitt orders diagnostic studies and I do not complete them in a timely manner, Dr. Prewitt and Health Care for Women, PA is not liable for any delayed diagnosis. I also understand that should I not abide by the Physician's recommendations I am terminating my care at Health Care for Women, PA.

_____ (Patient's Initials)

For your convenience, all ordered studies can be obtained on our website www.drprewittmd.com. It is your responsibility to contact the office for your user id and password. I understand that Dr. Maryann Prewitt is a Gynecologist only and that periodically she is out of the office. I understand that I need to have an alternate source to write my prescription(s) and treat non-Gynecologic problems in the event that Dr. Prewitt is not available. I also understand that refilling prescriptions is not an emergent GYN problem and they will not be filled outside of normal business hours or by a covering Physician. _____ (Patient's Initials)

Last Name: _____ First Name: _____ Middle Int: _____

Address: _____

City: _____ State: _____ Zip Code: _____

After 6 Phone #: _____ Day Time Phone: _____ Is there an Ext?: _____

Cell Phone: _____ Date of Birth: _____ SS#: _____

Marital Status: _____ Drivers License #: _____ State: _____

Insurance: _____ Insured's Name: _____

Insured's DOB: _____ Insured's SS #: _____

_____ DATE: _____ TIME: _____ AM/ PM

Signature of responsible party

If signed by a legal representative, relationship to patient: _____

(SIGNATURE OF WITNESS/EMPLOYEE): _____

I UNDERSTAND THAT IF I DO NOT HAVE A COPY OF THE FINANCIAL POLICY OF HEALTH CAREFOR WOMEN, PA, I WILL ASK ONE OF THE STAFF FOR A COPY.

Some health plans require that we inform you *in advance* that they may deny payment for “services not covered” and for “services not deemed by the health plan to be reasonable and customary or medically necessary.”

Health Care for Women, PA renders only services that, in their professional judgment are needed to provide quality medical care for you. In order for us to collect from you for our services when payment is denied by your health plan, your health plan requires that you sign the following agreement.

Agreement: I have been notified by the physician that payment may be denied for “services not covered” or for “services not deemed by the health plan to be reasonable and customary or medically necessary” or that have been specifically requested by me, the patient.

If payment is denied, I agree to be personally and fully responsible for payment.

Signature: _____ Date: _____

Health Care for Women, PA is committed to providing you with the best possible care and helping you to receive your maximum allowable benefits under your health plan. In order to achieve these goals, we need your assistance.

REGARDING OFFICE VISITS, LAB WORK, SONOGRAMS & ANY TESTING

It is your responsibility to know if a referral is necessary for your visit.

If you miss your appointment without 24 hours notice, you will be charged a no-show fee of \$25.

It is your responsibility to check with your insurance if any tests we request (mammogram, bone density, sonograms, MRI, labs, etc) are covered or need referrals.

Co-payments/co-insurance is due at time of visit.

A valid, current insurance card must be presented at each office visit.

If the service is not a covered benefit or if your plan tells us you are not covered, payment in full **is due for all services rendered**. If your insurance company subsequently makes a payment, any overpayment will be refunded to you.

Some insurance plans require that your laboratory services be submitted to either Lab Corp or SmithKline Quest. These laboratories will submit charges to your insurance company. In the event your insurance company does not pay you will receive a statement from one of these two companies. Please contact the number on their statements regarding questions about your lab charges. HCFW does NOT contract with Labone.

REGARDING YOUR HEALTH PLAN

Your insurance is a contract *between you, your employer and the insurance company*. **WE ARE NOT PART OF THAT CONTRACT.**

While we may have an agreement with many of the health plans to provide services, you must resolve any questions regarding coverage with the insurance company. Not all services are a covered benefit in all contracts: some health plans select certain services that they will not cover (i.e. contraceptives, elective surgery, cholesterol screenings, etc.).

We will confirm eligibility with your primary insurance company. All patients will be informed of benefits prior to your elective surgery. All patients are required to pay a deposit for this care dependent on your benefits (i.e. deductible and co-payment etc.)

When we confirm your eligibility, your insurance company will say this is a quote of benefits, and not a guarantee of payment. Therefore, we are only giving you an ESTIMATE of benefits. We will file with your insurance for all surgical procedures performed by Dr. Maryann Prewitt.

I am assigning benefits to the provider. In the event of non-payment by my insurance carrier within 45 days, I will be responsible for full payment. I will then have to seek reimbursement from my insurance carrier. Upon receipt of statements, if payment is not received within 14 days, collection process will be initiated. I also understand that I am responsible to provide the office with any insurance changes 24 hours prior to my appointment.

_____ (Patient's initials)

I HAVE READ THIS DOCUMENT, UNDERSTAND AND AGREE TO THESE OFFICE POLICIES & ASSIGNMENT OF BENEFITS.

I HAVE RECEIVED, READ AND UNDERSTAND THE CURRENT FINANCIAL POLICY & GENERAL CONSENT.

I UNDERSTAND THAT SHOULD I REQUEST MY RECORDS BE SENT TO ANOTHER GYNECOLOGIST I AM INACTIVATING MYSELF AS A PATIENT.

I HAVE RECEIVED, READ AND UNDERSTAND THE SUMMARY OF THE NOTICE OF PRIVACY PRACTICES.

I UNDERSTAND MY FINANCIAL OBLIGATIONS AND AM AWARE OF LATE CHARGES IF MY FULL BALANCE IS NOT PAID IN 30 DAYS.

By signing below, I acknowledge that I have read this information and understand it completely.

Signature: _____ Date: _____

I DO NOT AGREE WITH THE FINANCIAL POLICY OF HEALTH CARE FOR WOMEN, PA AND WISH TO DISCHARGE MYSELF AS A PATIENT.

Signature: _____ Date: _____

Health Care for Women, PA

Name of Patient: _____

Patient Date of Birth: _____

Patient Privacy Directive

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please provide us with the phone number (s) that we or an automated service may leave messages regarding appointments:

Please provide us with the phone number (s) that we or an automated service may leave messages regarding treatments and /or test results:

Please provide us with the name (s) and phone number (s) that we may talk to regarding your appointments, treatments, billing and /or test results:

Please provide an email address that this office may communicate health information to you with:

Please provide a cell phone number that we may text health information to:

Please provide us with the name and number of your emergency contact:

You must inform us **in writing** of any changes in your directives.

I acknowledge that everything above is accurate.

Signature Printed Name Date

I acknowledge I have seen or been offered a copy of the "Notice of Privacy Practices"

Signature Printed Name Date

Relationship if Patient Representative Physician Office Representative