

Patient Consent form

Femina Women's Center Pa
706 Green Valley Rd. Suite 506
Greensboro, NC 27408
336-389-9898

Patient Consent, Financial Agreement/Policies, HIPAA Notice of Privacy Practices Receipt

Consent for Diagnosis and Treatment

I, _____ having a condition requiring
(PRINT NAME)
healthcare, hereby consent to the provision of such care as the providers of this practice considers necessary. I understand that students training to become physicians, nurse midwives or other health professionals may observe or assist in providing my care.

Financial Agreement/Policy

I certify that the information given by me in applying for payment of third party payer benefits, directly provided to The Femina Women's Center is accurate. I hereby authorize payment of any third party payer benefits to The Femina Women's Center. Primary insurance will be filed as a courtesy by the practice. All secondary insurances are to be filed by me. Copies of the **Explanation Of Benefits** and claims will be provided by the practice upon request.

I understand that I am financially responsible for, agree to pay and guarantee payment in full of any charges for services provided to me by The Femina Women's Center; even if such treatment is not covered by insurance. I understand that my billing statements will be sent to the address on file. I also understand that my insurance requires that a co-payment be collected at the time of visit. Failure to comply with this policy may result in being asked to reschedule my appointment. For surgical procedures and obstetrical care, Femina Women's Center will determine what your insurance company will pay for the service and you will need to make arrangements to pay what is deemed your responsibility prior to the procedure or delivery.

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Payment plan options and requirements are as follows:

- I will pay 100% of the patient responsibility on the first appointment.
- Other payment schedules are available to me as long as I contact the Femina billing office and approved for a payment plan.
- There will be a \$25.00 fee for checks returned for insufficient funds.
- Co-pays must be paid at time of appointment.
- I am responsible for notifying my own insurance company of an expected hospital stay. In most cases pre-certification is required.
- In the event my account becomes delinquent for a period of thirty (30) days, I hereby acknowledge that I will be immediately responsible for the balance, interest, court costs and/or attorneys' fees that result due to an outstanding unpaid balance.

We will gladly send copies of your medical records to other physicians at no cost to you. However, should you request copies for yourself or for other sources, a \$10.00 fee will apply. Please allow 48 hours for copying of medical records.

We will gladly fill out FMLA or disability forms. However, we require a fee of \$10.00 that must be paid in advance to fill out the paperwork. Please allow 3-5 business days for completion of these forms.

I authorize payment of any refund that is due of any overpaid insurance benefits to be paid to the appropriate payer in accordance with my insurance policy conditions. With regard to any refund due to me, I authorize application of such monies to be applied to any outstanding balance owed to the practice; I understand that any remaining credit due after payment of these outstanding amounts will be refunded to me.

Receipt of Notice of Privacy Practices

My signature below certifies that I have read, been offered/and or received a copy of The Femina Women's Center Notice of Privacy Practices.

Signature _____ Date _____