State of Georgia Lowndes County

VALDOSTA WOMEN'S HEALTH CENTER, PC
PERMISSION TO TREAT & WAIVER OF LIABILITY

PERMISSION TO TREAT. In presenting to this office, I voluntarily consent to the rendering of medical care for myself or the minor indicated below including diagnostic procedures & medical treatment by the medical providers within this facility or their designees, as they decide is necessary in their professional judgement. I understand that the services that will be provided to me by Valdosta Women's Health Center, P.C. may not be covered by Medicaid, Medicare, Tricare Standard, Blue Cross Blue Shield, or other insurance. In the event that charges for these services, supplies or drugs are denied by the above carriers, I agree to be held financially liable to Valdosta Women's Health Center, P.C. for the full cost of said charges. (Active Duty Military and Tricare Prime OB patients are exempt from this financial liability).
OFFICE VISITS ARE ON A CASH BASIS. Payment is expected at the time of service unless previous arrangements are made. By signing below, I promise to pay any sums not paid by insurance on my behalf. In the event that my account is turned over for collection, a fee of 38% of the balance will be added.

AUTHORIZATION TO PAY. I hereby assign and direct you (my insurance provider) to pay, without further notice from me, to Valdosta Women's Health Center, P.C., such amounts as may be payable to me for medical and/or surgical treatment. VWHC may release information needed for claims processing. I understand that I am financially responsible for non-covered charges. Copies of this authorization carry the same authority as the original.

Date _____

Signature of Patient (or Guardian) _____

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA),
I have received a copy of the Notice of Privacy Practices of Valdosta Women's Health Center, PC on the date indicated below. I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted at this Office. I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future, or if I have any questions with regard to this Notice of Privacy Practices, I may contact:

Privacy Officer
Valdosta Women's Health Center
604 East Park Avenue
Valdosta, GA 31602
Phone: 229-333-0277

_____ _____
Print Patient Name **Date**

_____ _____
Signature of Patient (or Guardian) **Date of Birth**

If you prefer our office to communicate with you via email and/or voicemail regarding your test results and appointment reminders and would like to give our office permission to do so, please provide your email address and acceptable phone numbers below. By leaving these lines blank, you are declining this option.

Email: _____

Phone Number with approved voicemail/answering machine: _____

State of Georgia Lowndes County

PATIENT FINANCIAL POLICY

COPAYS AND NO SHOWS

Proof of insurance & payment of co-payments & balances are required at each visit or the appointment will be rescheduled. If an appointment is missed without a call from the patient at least 24 hours in advance, **a $20.00 fee** will be charged which must be paid before future appointments will be scheduled. If a patient no shows 3 times, then they **will be dismissed** from our practice.

SELF-PAY PATIENTS

Payment is required in full at time of service for all services including surgeries for patients who are covered by insurance plans in which VWHC does not participate, without proof of insurance, or who have not met deductibles by time of service.

NON-PARTICIPATING INSURANCE PLANS

Patient with insurance plans in which VWHC does not participate must pay all charges at the time of service. The insurance company will be billed as a non-assigned claim as a courtesy. The insurance company will reimburse the patient on non-assigned claims. If the office receives payment for a non-assigned claim, the patient will receive a refund within 30 days of payment made by insurance.

EXTENDED PAYMENT ARRANGEMENTS (ESTABLISHED PATIENTS ONLY)

At least 50% of the total fee for an office visit must be paid at the time of service or 50% of the total fee for a surgical procedure must be paid prior to the procedure. The remaining balance must be paid over the next three months in equal monthly payments. Patients who fail to make a monthly payment will have their account sent to a collection agency plus a 38% collection fee and will be dismissed from the practice.

AUTOMOBILE ACCIDENT CASES

The patient will be treated as a self-pay patient. If a subrogation agreement is provided and the physician participates with the insurance carrier, the health insurance is billed. If an attorney is involved in the case, a letter of protection will be obtained whether an insurance carrier is involved or not.

PATIENT REFUNDS

The following criteria must be met prior to issuing a patient refund: there are no outstanding insurance claims, and there is no outstanding patient balance on the account.

DIVORCE CASES

In cases of divorce, the individual who receives the care is responsible for payment of copays, coinsurance and nonparticipating insurance balances at the time of service. We will not bill a divorced patient's spouse.

CHILD CUSTODY CASES

The adult who brings the child in at the time of service is responsible for payment at the time of service whether the account is considered self-pay, participating insurance, or non-participating insurance. If the noncustodial parent carries the insurance on the child, the office will bill that insurance company. VWHC does not get involved with divorced specifics. It is the parents' obligation to work out an agreement themselves or through the court system.

TRICARE PRIME AND ACTIVE DUTY

Active Duty Military patients and those enrolled in Tricare Prime been assigned to a primary care manager (PCM) by Tricare. ALL appointments require authorization with the exception of annual exams. **The patient is required to obtain authorization prior to their office visit and to verify that they still have a valid authorization with available visits.** If proof of authorization is not provided at check in, the patient must self-pay or reschedule.

LABWORK

All blood work and specimens are sent to QUEST DIAGNOSTICS for processing **unless otherwise specified by the patient**. Valdosta Women's Health Center, P.C., is **NOT** responsible for lab charges sent by laboratories other than that specified by the patient's insurance.

By signing below, I acknowledge that I have read and understand these policies:

_____ _____

Signature of Patient (or Guardian) **Date**

_____

Print Patient Name