



# PATIENT AUTHORIZATIONS

## PATIENT INFORMATION

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize Women's Health Specialists and their staff to release protected health information (PHI) included in my health record to the following individuals or entities:

### *Primary Care Physician/Other Healthcare Professionals:*

Name	Phone	Fax
_____	_____	_____
_____	_____	_____

### *Family Members/Others:*

Name	Phone	Fax
_____	_____	_____
_____	_____	_____

I understand that my medical records may contain information about but not limited to: alcohol/drug treatment, mental health, or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my PHI in accordance with the Notice of Privacy Practices. I also understand that records may be sent via telefax and I relieve Women's Health Specialists and their staff from any liability from mistransmission by telefax. A photocopy of this authorization shall have the same effect as the original.

### **Initials**

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of a Notice of Privacy Practices brochure from Women's Health Specialists. I understand that: 1) the Notice may be amended at any time, 2) notice of such amendment will be posted in the front office, and 3) I may obtain an updated brochure from the office during regular business hours.

### **Initials**

## METHODS OF COMMUNICATION

I prefer to be contacted by the following means: (Circle all that apply and **provide numbers**)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_ US Mail \_\_\_\_\_

I understand that Women's Health Specialists and their staff may leave general messages with others who may receive communications at the above locations or leave messages on answering devices at these locations. General messages include appointment reminders and billing/payment reminders, NOT test/examination results or other medical or personal information.

### **Initials**

## ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Women's Health Specialists for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance company.

### **Initials**

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Signature \_\_\_\_\_ Date \_\_\_\_\_

**Women's Health Specialists of Montgomery Co., P.A.**  
**6301 Executive Blvd.**  
**Rockville, MD 20852**



## Financial Policy Statement

Welcome to Women's Health Specialists of Montgomery Co., P.A., otherwise known as Women's Health Specialists. We are glad you have chosen our practice for your medical care. We ask that you **carefully read** and sign the following statement. We must emphasize that, as your medical care provider, our relationship is with you and not your insurance carrier. You are responsible for supplying our staff with your current insurance card prior to seeing the doctor. If you do not have your card, you will be required to pay for the visit in full, at the time of service. We will refund any overpayment to you upon determination of your benefits by your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, you are the sole responsible party for all charges incurred and guarantee payment thereof. If we are contracted with your insurance company, we will accept assignment. You will be responsible for your payment portion at the time of service. Failure to provide necessary referrals and/or authorizations or failure to provide current, accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and responsibilities. This includes obtaining any referrals and/or authorizations which your insurance company might require before care is provided.\* All co-pays, co-insurance and deductibles are due and payable at the time services are rendered. If we do not have a contractual relationship with your insurance company, you are responsible for 100% of the payment at the time services are rendered. Our practice is committed to providing the highest quality of treatment to our patients, and our charges are customary for our area. You are responsible for these fees regardless of any insurance carrier's arbitrary determination of "usual & customary" rates.

We accept as payment:

Cash\* Check\* Visa\* Mastercard

Should a monthly payment plan become necessary, arrangements can be made through our billing office. Failure to pay for services or adhere to payment arrangements will result in collection activity. All collection costs incurred by Women's Health Specialists including attorney fees (at 33 1/3 % of principal balance) will be the sole responsibility of the responsible party named herein.

In consideration of the services performed by Women's Health Specialists., you agree to abide by the terms of this Financial Statement.

I, \_\_\_\_\_ hereby authorize Women's Health Specialists. to apply for benefits on my behalf for services rendered.

I certify that the information I have provided is correct. I authorize the release of any necessary information, including medical information for this or any related claim to the health insurance I have provided. I permit a copy of the authorization to be used in place of the original. I may revoke this authorization at any time in writing.

\_\_\_\_\_  
Patient or responsible party signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
WHS Witness

\_\_\_\_\_  
Date



## Patient Responsibilities

1. Notify us of any changes in your address or insurance information at the time of the change.
2. Know your insurance policy. Every policy has its own rules and regulations. It is in your best interest to know what your policies are, and if referrals are required. If you come without getting proper referrals you understand that this means you become responsible for this service.
3. We order tests that are medically necessary. It is your responsibility to know what tests your insurance policy covers and does not cover. (This includes all lab and radiology tests.)
4. All appointments must be scheduled in advance.
5. Co-payments must be made at the time services are rendered. (This is a health insurance requirement.)
6. Pay your bill promptly. If there is financial hardship, please call (301) 770-4967 and ask for billing in advance of appointment.
7. There is a fee for copying medical records. It is \$10.00 processing fee plus \$.50 per page. Records take 14 days to process so make sure your release form is turned in the appropriate timeframe.
8. There is a \$32.00 fee on all returned checks.
9. Please be advised that we will only call you regarding test results that require additional testing or further discussion with your healthcare provider. This will require a consultation appointment. To protect your confidentiality, results will not be discussed over the telephone.
10. When needing a prescription refill of any kind, we will require 48 hours from the time of your call to process your request.

I \_\_\_\_\_ have read and understand the above policies.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

WHS Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you in advance for your cooperation and understanding.**

# NOTICE OF PRIVACY PRACTICES

*This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.*

## INTRODUCTION

At **Women's Health Specialists of Montgomery Co., P.A.**, otherwise known as **Women's Health Specialists**, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

## UNDERSTANDING YOUR HEALTH RECORD

Each time you visit Women's Health Specialists, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party can verify that services billed were actually provided
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

## YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Women's Health Specialists, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy practices upon request
- Inspect and copy your health record as provided for in 45CFR 164.524
- Amend your health record as provided for in 45CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction of certain uses and disclosures of your information as provided by 45CFR 164.522
- Revoke your authorization to use or disclose health information from a certain date forward (not retroactively)

## OUR RESPONSIBILITIES

Women's Health Specialists is required to:

- Maintain the privacy of your health information
- Provide you with a copy of this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this Notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revisions and have an updated brochure available at our office upon request.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received proper written revocation of the authorization.

## FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact our Privacy Officer, Arlene Anderson at (301) 770-4967.

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer, or with the Office for Civil Rights (OCR), U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or with the OCR. The address for OCR is:

Web address: [www.hhs.gov/ocr/](http://www.hhs.gov/ocr/)

## DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

### TREATMENT

We will use your information for treatment. For example, Information obtained by a nurse, physician, or other member of your health care team will be recorded in your file and used to determine the course of treatment that will work best for you. Women's Health Specialists will document in your health record their expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, Women's Health Specialists will know how you are responding to treatment. Upon your authorization to do so, we will also provide copies of various reports or tests to another physician to assist him or her in treating you if you are discharged from this practice.

### PAYMENT

We will use your information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies.

### REGULAR HEALTH OPERATIONS

We will use your information for regular health operations. For example, members of our medical staff or the risk or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare services we provide. Other administrative departments may use your health information when they have an operational function and need the information in order to complete their job duties.

### BUSINESS ASSOCIATES

There are some services provided in our organization through contacts with business associates. Examples include transcription and copying services, diagnostic testing facilities, and outpatient/inpatient facilities. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, we require the business associate to appropriately safeguard your information.

### COMMUNICATIONS WITH FAMILY

We may use or disclose information to notify or assist notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment.

### RESEARCH

We may disclose information to researchers when their research has been approved by an institutional review board that has established protocols to ensure the privacy of your health information.

### FUNERAL DIRECTORS

We may disclose health information to funeral directors, consistent with applicable law, in order for them to carry out their duties.

### ORGAN PROCUREMENT ORGANIZATIONS

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs or tissues.

### MARKETING

We may contact you to provide appointment reminders, either by telephone or via message on your telephone answering machine, or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

### FOOD AND DRUG ADMINISTRATION (FDA)

We may disclose health information to the FDA relative to adverse events with respect to supplements, products or product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

### WORKERS COMPENSATION

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs as established by law.

### PUBLIC HEALTH

As required by law, we may disclose your health information to public health or legal authorities charged with the prevention or control of disease, injury, or disability.

### LAW ENFORCEMENT

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Office for Civil Rights  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building  
Washington, DC 20201