

Please read, sign and bring with you to your appointment.

HIPAA - HEALTH INSURANCE PORTABILITY ACCOUNTABILITY

I understand that under Health Insurance Portability Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to; conduct, plan and direct my treatment and follow up among healthcare providers who maybe involved in my treatment directly or indirectly; obtain payment from third party payers; conduct normal healthcare operations.

I have read and understand ADVANCED OB-GYN PLLC notice of privacy practices. I understand that ADVANCED OB-GYN PLLC has the right to change the notice of privacy practices from time to time and that I may contact ADVANCED OB-GYN PLLC at any time to obtain a current copy of the notice in writing. I also understand that ADVANCED OB-GYN is not required to agree with my written request to restrict my protected health information.

Patient Signature

Date

PAYMENT AGREEMENT

I authorize payment of medical benefits to ADVANCED OB-GYN PLLC, for services rendered, including Medicare and NYS Medicaid.

I understand my claim to be submitted via electronic transmission for payment. I also; acknowledge that I am financially responsible for any copay, deductible or service my insurance carrier does not cover. I am responsible for the entire bill or balance of the bill as determined by ADVANCED OB-GYN PLLC and/or my Insurance carrier if the submitted claims or any part of them are denied for payment. I also; understand that it is my responsibility to obtain the appropriate authorization/referral required by my insurance carrier. I understand by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Patient Signature

Date

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process an insurance claim to ADVANCED OB-GYN PLLC. And/or my insurance carrier or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided by ADVANCED OB-GYN PLLC. A copy of this authorization will be sent to my insurance carrier or other medical entity, if requested. The original authorization will be kept at ADVANCED OB-GYN PLLC.

Patient Signature

Date