 **CONSENT TO TREATMENT**

(All Patients)

I am presenting myself for examination and treatment at CircleHealth OB/GYN and I voluntarily consent to the rendering of such care encompassing routine diagnostic procedures and medical treatment, by authorized agents and employees of the practice, and by its medical staff, or their designees, as may in their professional judgment be deemed necessary or beneficial. I further authorize electronic access of my pharmaceutical records, if applicable, for treatment purposes. I understand that my records will only be accessed by authorized individuals.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations in the practice.

I understand that information about my health may be disclosed to public health authorities charged with preventing or controlling disease.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Signature of Patient or Responsible Person\*\* Relationship**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Signature of Witness**

\*\* By signing above, I acknowledge that CircleHealth OB/GYN has informed me of their **Notice of Privacy Practices** for the protection and security of my healthcare information. I also acknowledge that upon request, CircleHealth OB/GYN will provide me with a copy of their **Notice of Privacy Practices**.

**­­FINANCIAL CONSENTS**

**(All Patients)**

**Release of Information: Assignment of Benefits, Payment Guarantee**

**AUTHORIZATON TO RELEASE INFORMATION:** CircleHealth OB/GYN is authorized to release to any insurance companies having coverage on me (or to the employer if coverage is under a group insurance plan) any information pertaining to the diagnosis and/or procedures relative to this practice visit(s). A photostatic copy of this authorization shall be considered as effective and valid as the original.

**ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY:** In consideration of services rendered, I hereby forever assign and give to LGH WomanHealth all rights, title and interest in the benefits payable for services rendered by said practice, provided by my policy (ies) of insurance. This transaction shall be for the recovery on said policy (ies), but shall not be construed to be an obligation of CircleHealth OB/GYN to pursue any such right of recovery. Provided, however, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier(s). I hereby authorize the insurance company (ies) to pay directly to CircleHealth OB/GYN all benefits due under said policy (ies) by reason of services rendered therein. I shall pay CircleHealth OB/GYN for all charges in excess of the sums actually paid pursuant to said policy (ies). A photostatic copy of this authorization shall be considered as effective and valid as the original.

**­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Patient or Parent if Minor Witness**

**MEDICARE CERTIFICATION**

**(Medicare)**

Patient’s Certification, Authorization to Release Information and Payment Request: I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize CircleHealth OB/GYN to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to CircleHealth OB/GYN or one of its affiliates on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. I further agree that I will furnish evidence along with the Medical Insurance Policy number(s) that said insurance plan payments have been exhausted or unavailable for payment prior to payment submission and anticipation of payment by Medicare. I assign payment for the unpaid charges for certain physician’s services. I understand that I am responsible for any health insurance deductibles and coinsurance.

**\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Patient’s Signature Witness**

Form: A-2, 10/30/19



**PLEASE RETURN THIS FORM ON YOUR APPOINTMENT DATE**

Dear patient:

Your insurance is a contract between you, your employer, and your insurance company. As physicians and health care providers, our relationship is with you, the patient. Our policies follow the coding guidelines set forth by the American Medical Association.

It is illegal and constitutes fraud for procedures or diagnoses to be changed once they have been billed to an insurance company. However, the medical record may be reviewed for data entry error or to determine if there is documentation to support the change.

When scheduling your examination, please indicate the nature of your visit, as this will determine the benefits your insurance company allows. **Many insurance companies have restrictions on annual examinations and birth control visits including problem visits, follow-up visits and infertility treatment.** If you have any questions regarding your coverage, you should contact your insurance company.

Please sign below to acknowledge;

1. I am aware of my insurance coverage and agree to pay charges not covered by my insurance carrier.
2. I have read your billing and coding policy above.
3. I agree to have CircleHealth OB/GYN bill charges to my insurance company, and accept assignment. (Payment made directly to CircleHealth OB/GYN)
4. This agreement remains in effect for all future services at CircleHealth OB/GYN.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form A-1, 10/30/19