Southern Maryland Women's Healthcare, P.A.
41680 Miss Bessie Drive, Suite 102 • Leonardtown, Maryland 20650
23127 Three Notch Road, Suite 104 • California, Maryland 20619
Phone: (301)997-1788 • Fax: (301)997-1790
www.smwomenshealth.com

Patient Name: ____ Date of Birth: ________________

PATIENT'S REQUEST TO USE/DISCLOSE PHI

1. Family Member/Friend. I request that the Practice disclose my PHI so that **only** the family member, other relative or close personal friend herein named who is involved with my care or the payment for my care **may have access to PHI:**
   ____

2. Restriction – Use or Disclosure. I request that the Practice use or disclosure of my protected health information ("PHI") described below:

   DESCRIPTION OF PHI: ____
   ____

   RESTRICTION REQUESTED: ____

3. Response. I understand that the Practice is not required to agree to the restrictions that I have requested.

4. Termination. I understand that the Practice may agree to a restriction and may also, in the future, terminate its agreement, but such termination will only be effective with respect to PHI created or received after I have been notified of the termination.

____ ____
Name of Patient (Printed) Date of Birth

____ ____
Signature of Patient Date Signed

VOICEMAIL AUTHORIZATION

I authorize Southern Maryland Women's Healthcare, its physicians and employees, to leave detailed messages specific to my medical care, including test results, on the telephone number(s) listed below. I understand when a voicemail message exists; it is no longer covered until the Health Insurance Portability and Accountability Act of 1996 and therefore is not protected from unauthorized access. This authorization is effective immediately. I understand that this authorization can be revoked at any time by submitting a written request to Southern Maryland Women's Healthcare. Unless revoked sooner, this authorization to release detailed medical information will expire in one (1) year from the effective date. This authorization pertains to voicemail messages only and does not extend to family members and/or other persons that may answer the telephone. This authorization is not required to receive care at Southern Maryland Women's Healthcare. Patients opting not to sign this authorization will receive medical information such as test results personally rather than via a voice messaging system.

Telephone Number(s): Primary: ______________________________ Secondary: __________________________

Patient Signature:_______________________________________ Date: ______________________________

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CONSENT FOR TREATMENT

- I authorize Southern Maryland Women's Healthcare, P.A. physicians, nurse practitioners and personnel to administer care, treat and/or perform any procedure, which is considered necessary and advisable by the physicians of Southern Maryland Women's Healthcare, P.A.
- I authorize Southern Maryland Women's Healthcare, P.A. to forward copies of my medical records to my primary and/or my referring physician for the purpose of treatment.
- I authorize any physician, health care practitioner, hospital or medical care facility to provide all information on the above patient's medical history to Southern Maryland's Women's Healthcare, P.A. *(An additional authorization form may be required by the other healthcare entity.)*
- I authorize payment directly to Southern Maryland Women's Healthcare, P.A. for medical/surgical benefits, if any, and otherwise payable to the patient under the terms of the patient's health insurance policy.
- I authorize Southern Maryland Women's Healthcare, P.A. to access my pharmacy benefits data electronically through Pharmacy Benefits Managers (PBM) to see what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.
- I have read this consent form carefully and understand its contents.

____________________________________ ________________________
Signature of patient Date

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that a copy of the Practice's Privacy Notice has been made available to me.

____________________________________ ________________________
Signature Date

____
Witness

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Financial Policy

Patient Name: ______________________________ Date of Birth: _____________

Welcome and thank you for choosing Southern Maryland Women's Healthcare for your OB/GYN care. We are committed to providing you with the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any questions you may have concerning a bill. Co-pays are due at the time services are rendered. As a courtesy to our patients, we accept cash, personal check, money order, Visa, MasterCard, Discover, and American Express. We also provide our patients the ability to pay for their accounts over the phone at (301) 997-1788.

In order to achieve our goal of providing you with the best care possible, we need your assistance and your understanding of our financial policy:

Missed or Cancelled Appointments and other fees:

- 24 hours notice is required to cancel and/or reschedule all appointments. Failure to do so will result in a $25 *No Show* fee.
- All co-pays are due at the time of service.
- There will be a fee of $35 for any returned checks to our office.
- Accounts referred to collections are subject to a 34% fee of that balance.

"In Network" vs. "Out of Network" Insurance

- Your insurance coverage and benefits are a contract between you and your insurance company and therefore all disputes must be handled between you and your insurance company.
- We are contracted with multiple insurers to accept assignment of benefits.
- If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a *self pay* patient.
- 48 hours notice is required to verify insurance benefits.

Payment in full is due at the time services are rendered:

- Co-pays and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are due during the check-in process. Failure to produce payment at check-in may result in your appointment being rescheduled.
- If you receive more than one type of service on the same day, you may be responsible for more than one co-pay.
- As a courtesy to our patients, we gladly accept cash, check, money order, Visa, MasterCard, Discover, or American Express.
- Failure to pay balances may result in discharge from the practice.

Additional Paperwork

- A 48 hour notice is required for all paperwork.
- There will be a $10 charge for any FMLA/disability form requests per condition or episode.

Self Pay Patients

- Payment plans are on an individual basis as needed. We will give you an estimate of what will be due at the time of service, and payment for services is due at that time.

Minor Patients:

- In compliance with HIPAA regulations, we are unable to discuss any details of services rendered or to produce an itemized bill for any parties that are not the patient, unless otherwise documented.

Collections and Outstanding Balances:

- The provider reserves the right to add a $25 monthly statement processing fee on any account that has an unpaid balance.
- Any outstanding balance after 60 days of the date of service may be referred to an outside collection agency. Accounts referred to an outside collection agency or attorney are subject to a collection fee of 34%, which will be added to the total balance due at the time of write-off.
- Patients with unpaid delinquent accounts or accounts which have been sent to collections may be discharged from our practice.

Payment Plans

- Our office will be happy to work with you in order to pay any balance due to our practice.

Refunds

- Refunds are issued to the appropriate party.
- Patient refunds will not be processed until all active or past due charges are paid in full.

By signing this document, I, _________________________________, have fully read and understand the financial policy of Southern Maryland Women's Healthcare.

I understand and consent to Southern Maryland Women's Healthcare to use an automatic dialer to reach me. I will cooperate with the billing department of Southern Maryland Women's Healthcare to ensure payment for my services. I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement.

______________________________________	______________________
Signature of Patient, Parent, or Personal Representative	Relationship to Patient
______________________________________	______________________
Witness Signature	Date

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Credit Card on File Policy

Patient Name: ______________________________________ Date of Birth: ________________

At Southern Maryland Women's Healthcare, we now require keeping a credit card on file as a convenient method of payment for the portion of services your insurance doesn't cover, but for which you are liable, i.e. deductibles, co-payments, cost shares, and co-insurance. If you decline this authorization, a billing fee of $25.00 will be added to your account for any unpaid balances that we must attempt to collect through mailing subsequent monthly statements. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will accrue monthly for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. **You will be notified before the processing of your card, only if the account balance is over $100.00.**

I authorize Southern Maryland Women's Healthcare to charge the portion of the above patient's bill that is their financial responsibility to the credit card ending in _____________.

I, the undersigned, authorize and request Southern Maryland Women's Healthcare to charge my credit card for balances due for services rendered that the above patient's insurance company identifies as their financial responsibility.

This authorization relates to all payments, including deductibles, co-insurances, co-payments, and any non-covered services provided to the patient by Southern Maryland Women's Healthcare.

_______________________________________ ___________________
Authorized Card Holder's Name Date

_______________________________________ ___________________
Authorized Card Holder's Signature Relationship to Patient

I decline the offer by the Practice to store my credit card information on file. By signing below, I understand that the above fees will be added to my account for any unpaid balances.

_______________________________________ ___________________
Signature Date