Hancock Women's Center

Notice and Acknowledgement of Policies and Practices

PATIENT NAME: _____ _____
(Please Print) ***Date***

Please read the following and initial to the left of each statement:

_____ By signing below, I understand that charges not covered by Medicare and Managed Care will be my (the patient) responsibility. I recognize that current and valid insurance information is necessary for reimbursement. I hereby authorize the attached insurance companies to directly pay Hancock Women's Center the benefits due on my behalf, if any, as provided in the above interminable policy. I agree to pay all charges for all services not permitted or covered by insurance and subject to deductibles or co-payments. I acknowledge and agree to, in advance, pay for all outstanding amounts that, if greater than 30 days, will be assessed a finance charge of 1 ½% per month, and all court and attorney fees should my account be turned over to a collection agency.

_____ By signing below, I (the patient) hereby consent to the use and disclosure of protected health information for the treatment, payment, and health care operations. I understand I have the right to review the *Notice of Privacy Practices for Protected Health Information*. I understand I have the right to restrict how protected health information is used or disclosed. Hancock Women's Center is not required to agree to any restriction however, if agreement is reached, they are bound by the agreement. I further understand I have the right to revoke this consent in writing, except where disclosures have been made reliance on my prior consent. I acknowledge by signing below that I have read and agree to comply with the policies and procedures of Hancock Women's Center.

_____ By signing below, I agree to any testing deemed medically necessary by the health care providers of this facility.

_____ _____
Patient/Guardian Signature ***Date***

Voluntary Authorization to Release Health Care Information *(Optional)*

I, _____, a patient at Hancock Women's Center,
(*Printed Patient Name*)

voluntarily authorize this facility to release ALL of my medical records and health care information to the following person(s):

FULL NAME	**RELATIONSHIP**	**PHONE #**
		( )
		( )
		( )

I understand that these medical records and health care information may include and are not limited to the following: appointments, scheduling, and referrals; insurance and financial arrangements; medical care and treatment involving sensitive information related to surgical, medical, and office procedures, lab testing and results, imaging studies, medications, HIV/AIDS, STDs, and psychological, psychiatric, drug, and/or alcohol abuse diagnosis and treatment.

I understand that I have the right to revoke all or part of this authorization in writing by removing any or all names from the above list, and that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____
Patient Signature Only ***Date***