COVINGTON
WOMEN'S HEALTH
SPECIALISTS

PATIENT ACKNOWLEDGEMENT AND
RECEIPT OF HIPAA PRIVACY NOTIFICATION

Covington Women's Health Specialists receives, creates or maintains certain individual health information used to arrange payment, carry out treatment, or to conduct hospital operations. Each individual has a right to read the notice required by general law which describes such uses and disclosures before signing this contract. Covington Women's Health Specialists reserves the right to change its privacy practices. The terms of our notice may change. To receive a revised notice please request a copy in writing to: Privacy Officer, Attn: Medical Records Department, 4181 Hospital Drive, Suite104, Covington, Ga. 30014.

Each individual may request restrictions on how personal health information is used or disclosed to carry out payment, treatment or health care operations. Covington Women's Health Specialists, LLC is not obligated to agree to any restrictions.

Each individual may contact the office at any time, in writing only, regarding our privacy practices at: Privacy Officer, 4181 Hospital Drive, Suite104, Covington, Ga 30014.

This acknowledgement is extended to individuals or entities that participate in a health care arrangement with Covington Women's Health Specialists, LLC. This includes, but is not limited to Alcovy Regional Homecare, Covington Pediatrics, Southeastern Neurology, Newton Emergency Medical Services, Physicians practicing or consulting in the facilities, Anesthesiologists, Pathologist, Radiologists, Speech Therapists, ER Physicians, Imaging Centers, Lifelink providers, Eligibility Specialists, Emergent & Non-emergent transport personnel and Home Health Practitioners.

I/we agree that I/we have received the HIPAA Privacy Notice for Covington Women's Health Specialists, LLC.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE ABOVE FOREGOING, AND IS THE PATIENT OR DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

Patient (print) _____ date _____

Patient (signature) _____ DOB _____

Patient representative _____ Relationship _____

Witness _____

COVINGTON WOMEN'S HEALTH SPECIALISTS

Financial Policy and Consent for Treatment

Covington Women's Healthcare Specialists, LLC is pleased to provide your medical care. Please read our Financial Policy and Consent for Treatment. If you have questions or concerns, our staff will be happy to assist you.

Financial Policy:

- As a patient at Covington Women's Healthcare Specialists, you assume personal responsibility for your account with us.
- Medical insurance is a contract between you and your insurance company. It is your responsibility to know limitations exclusions, deductibles, and co-pays of your insurance plan and to resolve any disputes with your insurance carrier for nonpayment of services. As the insurance policy holder, you are responsible for timely payment of your account for any unpaid balances as indicated by your insurance.
- As a courtesy to you, we will file your insurance claims for our services.
- By law, we are required to collect your co-payment at each visit.
- We will collect your co-payment before you see the provider at each visit.
- If you have a deductible, it must be paid at the time of visit.
- Depending on your coverage, you may be required to pay a percentage of the visit charge at the time of your visit.
- For services not covered, payment is required at time of the service.
- Because we realize that temporary financial problems occur, we are willing to work with you regarding your account if we are notified promptly of your hardship. Interest of 1.2% per month will be charged on payment plans.
- Balances over ninety (90) days old may be placed with our attorney or collection agency. All fees charged by the attorney or agency will be added to your balance (additional 15%).
- There is a thirty five dollar ($35.00) fee for checks not honored by your bank in addition to the amount of the check.
- We do not re-deposit checks.
- To cover electronic payment processing of your credit card payment, a 3% fee will be added to all credit card transactions. For example, a $20 co-payment will be charged as $20.60.

PLEASE READ CAREFULLY:

I hereby authorize Covington Women's Healthcare Specialists, LLC to furnish information to insurance carriers concerning my visits, illnesses and treatments and I hereby authorize direct payment of medical benefits to Covington Women's Health Specialists, LLC for services rendered to myself or to my dependents. I understand that I am financially responsible for any balance not covered by insurance. If my Medicaid, Peachstate, Wellcare, Amerigroup, or any other insurance is terminated during the time of my date of service, I will be billed and held financially responsible for the balance. Failure to pay may result in collection actions as described above and future appointments being cancelled and/or being terminated from the practice.

Consent for Treatment:

I understand your practice is not a party to the contract between me and my insurance carrier. **It is my responsibility to know what services my insurance covers, what services need pre-certification and how much my insurance will pay for services.** I am aware that not all services are covered by insurance. Each individual carrier decides which services will be covered. I may be responsible for charges not covered by my insurance carrier. Even though every effort will be made to collect from my insurance carrier, the ultimate responsibility for charges is mine. I will let you know immediately about any changes in my insurance coverage.

I give Covington Women's Health Specialists, LLC, consent to provide such diagnostic procedures, treatment and care as, in the opinion of the provider, may be necessary or appropriate. I understand that medicine is not an exact science and no guarantee has been made as to the results of the treatment or care rendered.

Any photos submitted to our office may be used in social media advertising and/or printed publications.

I consent and authorize Covington Women's Health Specialists, LLC to use and disclose any medical information deemed necessary and without restriction.

I have read and understand these Policies and Consents. By signing this consent, I acknowledge that I have been offered a copy of this consent form.

_____ _____ _____

Patient/Parent/Guardian Signature DOB Date

_____ _____

Print name Witness