Date ____________

INNOVATIVE WOMEN'S HEALTH
GYNECOLOGY · MIDWIFERY · OBSTETRICS

CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I, ____________________________ (DOB: ___________) understand that as part of my healthcare INNOVATIVE WOMEN'S HEALTH, LLC creates and maintains records of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for healthcare treatment or to conduct health care operations. I hereby consent to the use and/or disclosure of my protected health information for these purposes.

I understand that my protected health information includes any information about my health that has been created or received by INNOVATIVE WOMEN"S HEALTH, my physician, another healthcare provider, my health insurance plan, my employer, or any health care clearinghouse and may include health information related to my past, present, and future physical or mental health or condition and that this health information identifies me or may be used to identify me.

I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging, and/or electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account.

I understand that I must sign this form or INNOVATIVE WOMEN'S HEALTH may refuse to provide health care services to me. I also understand that INNOVATIVE WOMEN'S HEALTH's treatment practices may include sending out postcard reminders and notices regarding my continuing health care and that name may be included in a directory for internal use by INNOVATIVE WOMEN'S HEALTH.

I have been provided a copy and understand that I have the right to read and review INNOVATIVE WOMEN'S HEALTH's *Notice of Privacy Practices* before signing this consent form. INNOVATIVE WOMEN'S HEALTH's *Notice of privacy Practices* provides a more complete description of the uses and disclosures of my protected health information and my rights related to this use and disclosure of my protected health information. I understand that I may receive a revised copy of the *Notice of Privacy Practices*, if I ask for one.

I understand and acknowledge that I have the right to request that INNOVATIVE WOMEN'S HEALTH restrict how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. I understand that INNOVATIVE WOMEN'S HEALTH is not required to agree to the restrictions that I request, but if it does agree to my requested restrictions then INNOVATIVE WOMEN'S HEALTH is bound to those restrictions. **I consent for the following people to the use or disclosure of my protected health information:**

Names: ____

INNOVATIVE WOMEN'S HEALTH hereby ☐ ACCEPTS ☐ DENIES this requested restriction

IWH representative/title ______________________________ Date: ______________

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that INNOVATIVE WOMEN'S HEALTH has already taken action in reliance upon it.

Signature of Patient/Legal Representative ______________________________

Printed name of Patient/Legal representative ______________________________

Relationship to the patient: ______________________________ Date: ______________

Cancellation Policy/No Show Policy
For Doctor/Midwife/Nurse Appointments and Surgery

1. *Cancellation/No Show Policy for Doctor/Midwife Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charge twenty-five-dollar ($25) fee; his will not be covered by your insurance company.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time. **If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.**

3. *Cancellation/No Show Policy Surgery*

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If procedure is not cancelled at least 10 days in advance you will be charged a seventy-five-dollar ($75) fee; this is will not be covered by your insurance company.

4. ***Account Balances***

We will require that patients with self-pay balances do pay their account balance to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____________________________ _____________________________ __________

Print Patient Name | Patient Signature/Guardian | Date

Patient Name: ______________________ DOB: ____________ DATE: ____________

INFORMATION REGARDING YOUR ANNUAL GYN EXAM VISIT

You are scheduled for an annual gynecologic/preventative exam today. At this visit, we will be addressing routine topics of your general health.

If you have additional concerns beyond the realm of a routine annual gynecologic exam, we will do our best to address your needs. However, it may be necessary to reschedule the annual gyn/preventative exam visit or schedule a follow-up visit to address your concerns more thoroughly.

If we can address all your concerns today, we are happy to do so. However, proper coding & billing requires that we code & bill for the services we provide. Please be aware that your insurance company defines "physical/preventative" care differently than a "problem visit" and may charge a copay or put the charge towards your deductible.

If you need to address additional concerns outside of the routine wellness scope, we have TWO options:

1. We could complete both the physical and treat the "problem" during the same visit if time allows. We then need to code and bill for both services, and your insurance company will most likely require you to pay the copay and/or deductible for the "problem".
2. If your medical concern if too significant to completely address during the physical, we will treat the medical issue and reschedule the physical/preventative exam. Then your insurance will cover the wellness exam.

Our goal is to work together to provide you the best medical care we can and have you be able to use your insurance benefit to the fullest.

____

Patient or Parent/Legal Guardian Printed Name

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Patient or Parent/Legal Guardian Signature

____

Date