

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have had the opportunity to review a copy of **North Florida OB/GYN's Privacy Notice** dated **February 28, 2011** ("Notice"). I understand that I am responsible to read this Notice and notify North Florida OB/GYN, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand the notice included electronic access to my medication history. North Florida OB/GYN has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.nfobgyn.com. North Florida OB/GYN will provide me with a copy of its most recent Notice upon my request.

Patient Signature: _____ Date of Birth: _____

Parent, Guardian or Legal Representative Signature: _____

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at North Florida OB/GYN. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services. For surgery and pregnancy, North Florida OB/GYN will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, procedure or pregnancy, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. Any patient credits will be applied to my other outstanding patient balances prior to any refund issued. I further understand that such payment is not contingent on any insurance, settlement or judgment payment.

North Florida OB/GYN may file a claim for payment with my insurance company as required by contractual agreement. If the insurance company fails to pay North Florida OB/GYN in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to North Florida OB/GYN. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is **my responsibility** to provide North Florida OB/GYN with a copy of my **current insurance** card and, if required by my insurance, **to obtain a referral** from my Primary Care Physician. North Florida OB/GYN is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify North Florida OB/GYN immediately upon any change to my insurance.**

INSURANCE WAIVER , NON-COVERED SERVICES WAIVER and OUTSIDE LAB SERVICES

I understand that if I do not have a copy of a current insurance card and/or valid referral, North Florida OB/GYN is not obligated to see me. But if I still wish to be seen, I can be seen as a "Private Pay" patient. I agree that neither North Florida OB/GYN, nor I, will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan "Non-Covered Services"; I understand I must pay for Non-Covered Services. If feasible, a waiver will be completed for each Private Pay visit or Non-Covered Service. I understand services sent to an outside lab are billed to my insurance or me by the lab and I will receive a separate invoice from the lab.

ANNUAL EXAMS (Including Medicare Annual Visits)

Annual “well-women” exams are preventive visits and are not paid for by all insurance carriers. Medicare only pays for a portion of this exam (Pap, Pelvic and Breast Exam) once every two (2) years. I understand I am responsible for payment, if the exam or portion of the exam is not covered by my insurance.

Annual exams do not typically include problems I may be having – as problem visits may require longer time. If I am experiencing problems, the office may be required to reschedule another visit to address these concerns.

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment.

ADDITIONAL INFORMATION

North Florida OB/GYN accepts payments in: Cash, Check, Debit and Credit Cards.

I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, for telephone management services, for educational materials, for payment agreements which extend beyond 12 months, and for other administrative expenses not covered by my insurance plan.

In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to North Florida OB/GYN.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to **North Florida OB/GYN**. I hereby authorize **North Florida OB/GYN** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient’s Printed name _____ Patient’s Date of Birth: _____

Patient’s Signature: _____ Date signed: _____

Parent, Guardian or Legal Representative Signature: _____

Employee’s signature who reviewed intake of form: _____