

The Counseling & Gynecology Group, P.C.

Patient Name: _____ **DOB:** _____

ASSIGNMENT OF BENEFITS / CONSENT FOR Treatment, Payment & Health Care Operations By signing below, I understand that I hereby authorize the Practice to disclose my medical information so that the Practice may treat, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations. I understand that I am responsible for payment in full of all charges. I request that payment of authorized Medicare and other insurance benefits be paid directly to The Counseling and Gynecology Group. I also authorize The Counseling and Gynecology Group to release all information necessary for the processing of insurance claims to HCFA, its agents or any other insurance company to determine benefits payable for related services.

SIGNATURE: _____ **DATE:** _____

INSURANCE STATEMENT OF UNDERSTANDING

This office will gladly submit your private insurance claims for office/surgical services rendered. You must supply us with your current ID card. All efforts will be made to collect your insurance benefits. Your insurance coverage is a contract and is your responsibility. You are also responsible for any non-covered services as well as obtaining and maintaining a current referral and any services denied by the insurance company. Co-payments are due at the time of your office visit.

COPAY POLICY

Many health insurance plans require a copay for services rendered, which is expected at the time of service. If we must bill you for your copay, a \$ 10.00 service charge may be added.

OVERDUE PAYMENT POLICY

Interest will accrue at the rate of 0.5% monthly on accounts 60 days past due.

PRESCRIPTION REFILL POLICY

Prescription refills require a clinician's approval. Prior authorization from your insurance company may be required. For these reasons please note our refill policy. Gynecologic prescriptions require 3 days advance notice. Psychiatric prescriptions require 1 week advance notice. Any mail order or prior authorization prescriptions require 2 weeks advance notice.

This policy is necessary so that you will not run out of your medication.

"NO-SHOW"/ CANCELLATION POLICY

If you cannot keep your scheduled appointment, please call one full business day in advance to avoid no show office charges. We reserve the right to charge \$30 to \$60 for missed appointments. If you repeatedly "NO SHOW" and/or CANCEL your appointments, we reserve the right to discharge you from care.

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS, AND/OR OTHER REPRESENTATIVES

By signing below, I have authorized The Counseling and Gynecology Group to disclose my Protected Health Information to the following family members and/or friends:

Name Relationship Telephone #

Name Relationship Telephone #

SIGNATURE: _____ **DATE:** _____

Notice of Privacy & Acknowledgement Form given to patient: DATE: _____