**Authorization Form for Release of Protected Health Information with Family or Friends**

**Patient Name: _____ DOB: _____**

I grant permission for my healthcare provider and their representatives of SOWC to discuss my care using this disclosure form to share relevant information about my healthcare or discuss financial information for payment on my account with family or friends.

- **I consent to SOWC to leave a message on my voicemail/answering machine regarding my lab test results ☐ Yes ☐ No**

☐ **I do not want any of my information shared with family or friends**

**Release my protected health information to the following person(s)/entity:**

Name: _____ Phone:_____ Relationship: _____

Name: _____ Phone:_____ Relationship: _____

Name: _____ Phone:_____ Relationship: _____

**The information you may release subject to this authorization is the following:**

Appointment date/time ☐ **Yes** ☐ **No** Explanation of diagnosis and/or procedures ☐ **Yes** ☐ **No**

Lab reports ☐ **Yes** ☐ **No** Billing information ☐ **Yes** ☐ **No**

I understand that my healthcare information at Seven Oaks Women's Center is protected. I have received this Notice of Privacy Practices and this document will be on record with SOWC.

_____

Patient Signature Date

**This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to Seven Oaks Women's Center.**

Seven Oaks Women's Center Patient Consent Form

By signing this form, you are granting consent to Seven Oaks Women's Center to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice before you sign this consent and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our health information office at: 210-692-9500.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Patient Name (Print): _____

Signature: _____

Date: _____

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**Office Use Only:**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this

Acknowledgement but did not because _____

_____

Signature of Privacy Officer

SEVEN OAKS
WOMEN'S CENTER

**FINANCIAL POLICY**

Thank you for choosing Seven Oaks Women's Center as your health care provider. We are committed to providing you the best available medical care. Our personnel will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy as well as complete our Patient Information form prior to seeing the physician.

Payment for service is due at the time services are rendered. We accept **cash, check, Visa, American Express, Discover** and **MasterCard.** We will be happy to help you process your insurance claim for your reimbursement.

In special instances, we may accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges.
   We are however, contracted with certain managed care, and preferred provider plans; we will follow the guidelines for patient care, reimbursement, and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.

2. **All charges are your responsibility whether your insurance company pays or does not pay**. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3. **Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.**

4. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. **You will be responsible for any unpaid claims**.

5. If your insurance company does not pay in full within 45 days, we require you to pay the balance by **cash, check, Visa, American Express, Discover, or MasterCard.**

6. **Lab Billing –** Please remember, your lab billing is separate from our physician's billing and you may receive a separate itemized bill from the laboratory, for which you are responsible. Please verify that you are being directed by our office to a lab that is a participating provider with your insurance plan.

7. Returned checks and balances older than 45 days may be subject to collection placement and collection fees.

8. **Effective January 1, 2013** a charge of $5.00 will be collected when requesting itemized patient account information.

9. FMLA/Disability Forms charge is $20.00, due at time of request.

Please note that, if you must cancel or reschedule your appointment, **all cancellations must be made at least 24 hours in advance. If you fail to cancel your appointment, you may be charged at the rate of a normal office visit**. We encourage you to communicate with our business office any payment problems, so that we may assist you in the management of your account. Again, thank you for choosing Seven Oaks Women's Center as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient's Signature: _____ Date: _____