Patient Name: ________________________________

DOB: ___________________

PATIENT CONSENTS AND AUTHORIZATIONS

AUTHORIZATION OF INSURANCE PAYMENT AND FINANCIAL RESPONSIBILITY: I authorize insurance payment directly to Kalispell OB/GYN for services rendered. *I understand that it is my responsibility to know my insurance benefits and how obstetrics and gynecology services are covered under my plan.* I understand that I am responsible for providing Kalispell OB/GYN with any and all insurance coverages at each and every visit. I accept full responsibility for payment of services not covered by my insurance; including co-payments, co-insurance, and deductibles. I understand and acknowledge that fees charged are for the provider and services completed by Kalispell OB/GYN only. Any labs, pathology, and related services performed by or ordered by my provider will be sent for examination and billed separately by a different vendor. *I understand it is my responsibility to ask about any test prior to the test being done if I am concerned about cost*. If my insurance requires the use of a *specific lab facility*, I understand it is my responsibility to inform my provider/nurse *BEFORE lab/pathology is performed* for proper handling.

I understand that I am ultimately responsible for payment of my account and that payment of co-pays and pre-payments are expected at the time of service. Kalispell OB/GYN will file insurance claims for all companies, including but not limited to Medicare, Medicaid, and Tricare. I understand and accept that if I make a payment with a check and that check is dishonored or returned for any reason, I will be assessed an additional fee of $25 to my account. *I understand that if I do not pay all of the charges due, my past due account may be turned over to an outside collection agency.* I authorize Kalispell OB/GYN and any third-party collection agents to use all contact information I have provided.

CONSENT OF SERVICES: I consent to the evaluation and treatment performed by my licensed provider. I understand that any labs or pathology that are completed at my appointment will have results that need to be reviewed. I understand that if Kalispell OB/GYN has not contacted me within 2 weeks with those results, it is my responsibility to call to confirm and review the results. I understand that Kalispell OB/GYN uses electronic prescribing. My prescriptions will be sent and my medication information may be obtained through the electronic prescribing function. I do hereby authorize my provider to release information to the hospital facility in the event of a scheduled surgery or procedure, emergency care, or pregnancy. I authorize the release of any medical records or other information necessary to other providers for my ongoing care or as required by my insurance company.

CANCELATION POLICY: Kalispell OB/GYN requires 24 hours' notice in the event of a cancelation. Kalispell OB/GYN reserves the right to charge a $40 "cancelation without notice" fee for any appointment I fail to show for without any notice or cancel with less than 24 hours' notice. *This charge will not be billed to insurance and MUST be paid prior to the start of my next visit.* After 3 cancelations without notice, Kalispell OB/GYN may dismiss me from the practice. Management approval may be required for rescheduling on a case-by-case basis.

NOTICE OF PRIVACY PRACTICES FOR MY PROTECTED HEALTH INFORMATION: I have been offered and/or given a copy of the Notice of Privacy Practices that describes how Kalispell OB/GYN may disclose and use my protected health information.

I have reviewed the consents and authorizations above and I agree to all of the statements.

____   _____________________

Signature of Patient or Parent/Legal Guardian   Date

If signed by patient's personal representative, please indicate:

Print name: ________________________________   Relationship to Patient: ____________________

(sign every year)