

***NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:***

By signing below, I acknowledge that I have been offered to see a copy posted in the office, or have received a copy of the Notice for Privacy Practices for Women’s Health Associates of Western MA, Inc. Notice of Privacy can be found at our website whaob-gyn.com

Signature of Patient or Patient’s Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_

***CONSENT FOR PRESCRIPTION HUB INQUIRY:***

I hereby authorize WHA to obtain my RX history using the SureScripts -RXHub network. I understand this will provide my physician with an accounting of my medication history reported by retail pharmacies and pharmacy benefit managers. I also understand that SureScripts - RX Hub has certified that RX History Capture follows strict security protocols to align with HIPPA requirements and respects patient privacy. I understand this authorization will remain in effect until revoked by me in writing.

Signature of Patient or Patient’s Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_

***AUTHORIZATION TO RELEASE INFORMATION:***

For billing purposes, I hereby authorize Women’s Health Associates to release any information necessary to process my insurance claim. I understand this authorization will remain in effect until revoked by me in writing.

Signature of Patient or Patient’s Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_

***FINANCIAL POLICY:***

It is your responsibility to understand the limits and restrictions affecting your insurance plan and coverage. If your insurance company requires you to use a specific lab, it is your responsibility to notify us of that. You will be responsible for all co-pays, deductibles, and co-insurance amounts not covered by your policy. For your convenience we accept cash, personal checks, American Express, Visa, MasterCard, Discover and CareCredit. Patients who do not have insurance coverage, (or proof of coverage) or who choose to pay for services, are expected to pay in full at the time of service. Payment arrangements can be made with our business office.

Signature of Patient or Patient’s Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_