
# PATIENT CONFIDENTIALLY

Azalea Women's Center follows HIPPA guidelines to ensure the integrity of your privacy. We need your help in ensuring your privacy by providing us with the following information. In the event I cannot be reached personally, Azalea Women's Center may leave any test result, lab result, appointment information, or other confidential medical information to the following designated individuals:

| Name | Relationship | Phone |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Azalea Women's Center may leave any financial information to the following designated individuals:

| Name | Relationship | Phone |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Release of protected health information to anyone other than the patient or guardian will be restricted to those individuals listed above.

Patient Signature_____ Date: _____

I hereby acknowledge that I have been made aware of the above Notice of Privacy Practices and acknowledge that it is available on the website, azaleawomenscenter.com and I may request a copy of the privacy notice. I understand that I may address any questions or concerns I have about the Practice's Privacy Policies.

PATIENT PORTAL ACCESS TO MEDICAL RECORDS

AWC allows you to access your medical information through our patient portal. If you would like access to you Patient Portal, we will send an e-vite to the email address below. The e-vite will contain a link, the link will guide you through the registration process.

Email address: _____

# FINANCIAL POLICY

We are committed to providing you with the best possible patient care. In order, to keep your financial responsibility as simple as possible we have the following financial policy in place.

If you have insurance, we will file it as a courtesy to you. All co-payments, co-insurance, and estimated patient portions will be due at time of service. Estimated patient portions for surgeries will be due prior to surgery.

Your insurance policy is an agreement between you, your employer and/or your insurance company. It is your responsibility to understand what services are covered, if you are in or out of network, have a deductible, or require authorization to be seen, etc. If payments is not received within 6 weeks from the billing date, you will be expected to pay the balance in full. If we receive an insurance payment after you have paid the balance, we will issue you a refund.

Any account balances from prior services will be collected before your next appointment. For your convenience, we accept cash and credit cards.

Non-payment may result in the rescheduling of your appointment unless there are financial arrangements in place.

Statements are mailed monthly for unpaid balances. It is the responsibility of the patient to monitor outstanding balances and pay accordingly. If there are questions concerning your balance, please call our office at 229-242-8888.

It is your responsibility to ensure we have your current address, primary contact number, and insurance information at each visit. If you do not have proof of your current insurance at your visit and we are unable to verify coverage you may be rescheduled or considered self-pay and payment will be due in full prior to services being provided.

Balances older than 90 days with no response from the guarantor may be turned over to our collection agency. Patient accounts turned over to a collection agency are also considered dismissed until all balances are paid in full. Patients with poor payment history will always have to pay estimated financial responsibility prior to being seen.

All returned checks will be subject to 35.00 processing fee.

Patient/Guarantor Name: _____ Date:_____

I have read, understand, and agree to the policies and procedures outlined above.

Patient/Guarantor Signature: _____ Date: _____