Women's & Family Care Patient Consent and Authorization

CONSENT FOR TREATMENT I voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of the attending/collaborative physician(s) and it is the responsibility of the staff to carry out the instructions of such Providers(s).

ASSIGNMENT OF BENEFITS POLICY/RIGHTS The undersigned patient hereby assigns the benefits of insurance under their health insurance or any other insurance to Women's & Family Care for services rendered to the undersigned patient. The undersigned agrees to pay any applicable deductible, co-payment or charge for services rendered not covered by the insurance company or any benefits of automobile insurance for services rendered to the undersigned patient and covered by Personal Injury Protection (PIP) coverage under insured's name policy in accordance with State Law. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement containing any false, incomplete or misleading information is guilty of a felony of the third degree. I have read the information herein and it is true to the best of my knowledge and belief. The assignment includes but is not limited to all rights to collect benefits directly from the patient's insurance company for services that the patient has received and all rights to proceed against patient's insurance company if it fails to make payment of benefits to which patient is due. This assignment also includes any right to recover attorney's fees and cost for such action brought by the provider as patient's assignee. The provider hereby objects to any partial payments made at the discretion of the insurer. Any partial or reduced payment, regardless of the accompanying language issued by the insured and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

NO SHOW I understand that if I do not provide a 24-hour cancellation notice for secured appointments, I will be charged a fee for a missed appointment. This fee is charged to me and not my insurance. I agree to pay this fee.

RELEASE OF INFORMATION The Practice/Providers may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract of the Practice/Providers, or to all or part of the Practice/Providers charges: including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer. In accordance with the HIPAA Privacy Rule, Uses and Disclosures for Treatment section (45 CFR 164.506). I authorize the release of my medical records and therefore authorize other healthcare providers involved in my "treatment" and "payment" (which is excluded from the HIPAA Rule) to release relevant medical records information in the amount of the minimum necessary to this Practice/Providers for reasons of "treatment" and "payment". This release allows the provider to receive insurance authorization telephonically from the insurer and to request a written non-redacted PIP payout sheet from the insurer.

ELECTRONIC INFORMATION I understand that any reference to the name Comprehensive Women's Care, Women's & Family Care, Modern Dermatology & Aesthetics and it's providers and staff is explicitly owned by Comprehensive Women's Care. Any derogatory comments made in writing, speech, electronically or otherwise regarding any of the entities or personnel will legally be considered slanderous and legal action will be taken at my expense. I understand that I will at times, receive emails from this group regarding appointments, educational material or other instances. I am free to block these emails from my inbox.

HMO DISCLAIMER I certify that I am not presently enrolled in any Health Maintenance Organization (HMO) or that if I am, I have the appropriate referrals required to be seen in this Practice. Subsequent rejection of a claim as a result of care received in this Practice will constitute responsibility for payment of the claim on my part.

LIFETIME AUTHORIZATION MEDICARE AND MEDICAID PATIENT CERTIFICATION – PATIENT CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST I certify that the information given me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I assign the benefits payable to the Practice/Providers/Providers services. I understand that I am responsible for my health insurance deductibles and co-insurance.

GENERAL RELEASE The Practice/Providers maintain insurance for medical malpractice at required by the State of Kansas. *The Practice/Providers liability to patient for any indemnity commitments or for any damages arising in any way out of the performance of this contract is limited to such insurance coverages and amounts. In no event shall the Practice/Providers be liable for any indirect, special or consequential loss or damage arising from the performance of services hereunder including, but not limited to, loss or use, loss of profit, no economic damages, guilt and suffering, whether caused by the negligence of the Practice/Providers, or otherwise, and patient shall indemnify (cover) and hold the Practice/Providers harmless from any such damages or liability. The patient agrees to indemnify (cover) the Practice/Providers for all attorneys' fees, court costs, and all related expenses incurred by the Practice/Providers as a result of any claims made against the Practice/Providers by the patient or his agents.* I understand that the waiver includes any claims based upon negligence, action or inaction of its employees. I agree to indemnify (cover) and hold the Practice/Providers harmless from sequelae of known medical conditions, outcomes or medications not expressly disclosed to the providers in writing during consultation.

_____ _____

Witness Date Patient Date

Patient is a minor ____ of age, or incapacitated, and I am the parent or legal guardian and do hereby consent for the patient. My relation to patient is _____.