



## ADVANCE NOTICE OF NON-COVERED SERVICE(S)

Many insurance carriers will only pay for services that they determine to be medically necessary. In many cases insurance only covers services that are for the treatment of illness or injury; they will not cover routine or screening services. Your doctor may recommend that you have one or more tests performed which may or may not be covered by your insurance. Your insurance may deny payment, even though your doctor feels that the service is medically necessary.

At your visit today, it is possible that your insurance company may deny payment for:

CBC	Urinalysis	STD Cultures	Hemoglobin
Glucose	Hormone Levels	Thyroid Function Tests	Hematocrit
Stool Hemmocult	Lipid Profile	Wet Prep	Pap Smear
Routine Exams	Cholesterol	Bone Density Testing	Other _____

\_\_\_\_\_ Your insurance company may not pay for this service for the provided diagnosis.

\_\_\_\_\_ We believe that this service may be non-covered by your insurance carrier.

\_\_\_\_\_ Other reason \_\_\_\_\_

I have been notified by my physician that he or she believes, that in my case, my insurance may deny payment for services rendered at the Center for Women's Health for the reasons stated. If my insurance denies payment, I agree to be personally and fully responsible for payment.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_



## GENERAL INFORMED CONSENT

I authorize the staff of Center For Women's Health to carry out all procedures ordered by my physician. I understand that all services are available and will be provided to all individuals regardless of age, sex, race, color, creed, national origin, religion or handicap. At any time while on the premises of Center for Women's Health, in the event of an emergency, I authorize Center For Women's Health or their employees to provide or obtain such medical treatment as may be deemed advisable under the circumstances. I consent to the release of my records to be reviewed by the authorized representatives of my insurance carriers. I authorize the review of my records for any necessary audits within Center For Women's Health, and for summary information to be released to referral sources. I understand that my record is the property of Center For Women's Health and will remain at Center For Women's Health at the end of my treatment. A copy will be made available to me upon request. This consent shall take effect as a sealed instrument and be construed in accordance with the laws of the Commonwealth of Virginia. This consent shall be binding upon and inure to the benefit of the parties, their successors, heirs, assigns and personal representatives.

Patient Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**CENTER FOR WOMEN'S HEALTH**

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

By \_\_\_\_\_ Title \_\_\_\_\_

## NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies pursuant to this provision, the testing would be explained and you would be given an opportunity to ask any questions you might have.

I have read and understand the above "Notice of Deemed Consent to HIV Blood Testing"

Patient Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## HMO OR PPO PATIENTS

If any services are performed in our office and prior authorizations have not been obtained, I am responsible for any deductions or copays that are generated from their out of network benefits.

Patient Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**FINANCIAL RESPONSIBILITY AGREEMENT**  
(All Patients and Non-patient Guarantors Must Sign)

We/I, \_\_\_\_\_ (Patient/Insured)  
and \_\_\_\_\_ (Insured/Non-patient Guarantor), understand and agree to abide by the billing, payment and collection policies of Center For Women's Health as set forth in this agreement and any other letters distributed to me concerning this matter. We/I accept the obligation to pay for all services rendered to the patient and further understand and agree that:

- (a) The execution of the agreement by the non-patient guarantor in no way relieves the patient of her liability for any and all charges by Center For Women's Health because this agreement intends to, and does, impose joint and several liability on the patient and the non-patient guarantor for those charges.
- (b) Center For Women's Health will file insurance claims with the appropriate insurance carrier(s) as a courtesy but recognize our obligation to pay any and all amounts due sixty (60) days after such claims are filed if Center For Women's Health has not received payment from the insurance carrier(s) by that date.
- (c) We/I are/am responsible for any co-payment, deductibles and fees for non-covered services that may accrue while the patient is being treated by Center For Women's Health.
- (d) We/I will not seek to defer payment for services rendered while awaiting any settlement, judgment or any insurance carrier payment if the patient is registered as a Litigation or Worker's Compensation case.
- (e) If we/I default in making payments according to this agreement and Center For Women's Health refers the patient's account to an attorney for collection, we/I will become liable for all reasonable legal fees and cost of collection to the extent permitted by Virginia state law.
- (f) This agreement shall take effect as a sealed instrument and be construed in accordance with the laws of the Commonwealth of Virginia.
- (g) This consent shall be binding upon and insure to the benefit of the parties, their successors, heirs, assigns and personal representatives.

**The non-patient guarantor specifically acknowledges that:**

- (1) The non-patient guarantor accepts and undertakes this obligation in consideration of his/her relationship to the patient and in consideration of Center For Women's Health's rendering of services to the patient.
- (2) His/her obligation under this agreement is an original, direct, independent and positive promise to pay and is not a contingent promise simply to answer for the debt of another.
- (3) He/she waives presentment, demand, protest and notice of every kind respecting this agreement.
- (4) Center For Women's Health may grant extensions of time for payment, at any time and without notice to or without the consent of the non-patient guarantor.



**PRIVACY STATEMENT**

Password \_\_\_\_\_

Hint \_\_\_\_\_

Dear Patient:

The Privacy Act of 1977 was designed to protect you. To give you a feeling of security, be assured that when you come into this office your medical and financial affairs will not be discussed without your permission. This means that your spouse, your personnel director, and even your parents have to have an authorization signed by you before they may receive information regarding your medical care.

It is a felony for the staff to give out this information without your written consent.

For those of you who wish for your husband, social worker, personnel director, parents, etc., to call this office and receive information about you or about your bill, please print and complete the form below. In order for us to give out information, any one who calls in will have to provide our staff with your social security number, date of birth and password which you will provide. If there is not anyone whom you would like to receive information about you, please draw a line through the bottom portion and sign and date it.

Thank you for your cooperation in this matter.

I, \_\_\_\_\_, give my permission for the staff of Center for Women's Health to release medical information to my \_\_\_\_\_,  
(Relationship)  
\_\_\_\_\_  
(Name)

I, \_\_\_\_\_, give my permission for the staff of Center for Women's Health to release medical information to my \_\_\_\_\_,  
(Relationship)  
\_\_\_\_\_  
(Name)

I, \_\_\_\_\_, give my permission for the staff of Center for Women's Health to release medical information to my \_\_\_\_\_,  
(Relationship)  
\_\_\_\_\_  
(Name)

I, \_\_\_\_\_, give my permission for the staff of Center for Women's Health to release medical information to my \_\_\_\_\_,  
(Relationship)  
\_\_\_\_\_  
(Name)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Signature