McDowell Mountain Gynecology

PATIENT INFORMATION

Last: _____First:_____
Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____Home Phone: _____
Date of Birth: _____ Age: _____ Social Security #: _____
Race: _____ Ethnicity: _____Language: _____
Responsible Parties Email:_____Phone :_____

EMERGENCY CONTACT NAME/NUMBER/RELATIONSHIP: **STATUS: M S W D**
_____

Referring Physician/PCP: **_____ Phone/fax: _____**

Pharmacy #/Location: _____

*****YOUR Email**: _____required for portal access

_____**Initial * I UNDERSTAND** that it is the policy of McDowell Mountain Gynecology to Deliver all test results via the patient portal system. I also understand that it is my responsibility to check the portal for any and all test results. I further understand that if I do not receive my test results via the portal and have not been notified of the results in any other manner it is ultimately my responsibility to contact McDowell Mountain to inquire of the results.

INSURANCE DISCLAIMER

As a courtesy, we will submit your claim for all services to your insurance company. Please remember your individual health insurance policy is a contract between you and your insurance company, we are not part of that contract. Be aware that some of our services may not be covered by your insurance policy. By presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance; we will not alter your claim, change diagnosis or report a different eservice than what was performed in order to have your insurance cover the charges. It is your responsibility to know your insurance policy. You will be held responsible for all charges.

CONSENT FOR TREATMENT/INSURANCE AUTHROIZATION AND ASSIGNMENT

I or my representative, recognizing the need for care, consent to call and any services deemed necessary and ordered by my physician, including bit not limited to, laboratory testing, medical and or surgical treatment examination and other services rendered under the specific instructions of my physician. I authorize and request that payments under my medical insurance programs be made directly to Rachel L Spieldoch, M.D. PLLC, for any services provided for me, understanding there is clear legal documentation of the treatment/visit. I also authorize the provider to release any information needed for payment of claims and further permit copies of this authorization to be used in the place of the original.

RESPONSIBLE PARTY: _____**DATE: _____**

PRINT NAME: _____

10617 N. Hayden Rd, Suite B102, Scottsdale, AZ 85260
Office: (480)483-9011 Fax: (480)483-2803
www.mmgyn.com

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HIPAA CONSENT FOR PAYMENTS **NAME:_____**

This is a patient consent for records release for disclosure of protected health information with credit card, debit card and financial disclosure disputes.

All services rendered by McDowell Mountain Gynecology are billable and due upon service unless contractually agreed upon otherwise. Once treatment is received this is NON-REFUNDABLE.

Services performed that are paid with a credit card, debit card, check or financing third party is not eligible for challenges after the service has been provided. There is Document, legal proof of every service provided.

By signing this form, I am irrevocably consenting to allow McDowell Mountain Gynecology and all of its affiliates to use and disclose my protected health information to any financial entity (credit card, debit card, bank of financing) if they request such proof to assist in the processing of the payment.

PLEASE READ, REVIEW AND INITIAL THE FOLLOWING STATEMENTS:

_____**I agree** to the statement above and I WILL NOT challenge, credit, debit or financing payments once services are provided. I understand that by consensually receiving services I am bound to this payment.

_____**I DO NOT AGREE** and will pay for services rendered each time with a cashiers check, money order or cash. I understand that the amount due for such services will be required to be paid in full before each service is rendered.

NAME:_____SIGNATURE: _____

Date: _____

NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____**I UNDERSTAND** that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

_____**I UNDERSTAND** that McDowell Mountain Gynecology may use or disclose my protected health information for treatment, payment or health care operations – which means for providing health care to me, the patient; and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information.

McDowell Mountain Gynecology has a detailed document called the "Notice of Privacy Practices". It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I UNDERSTAND that I have the right to read the "Notice" before signing this agreement. If I ask, McDowell Mountain Gynecology will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given that chance to review the Notice of Privacy Practices. My signature means that I agree to allow McDowell Mountain Gynecology to use and disclose my protected health information to carry out treatment, payment and heath care operations. I have the right revoke this consent in writing at any time; accept to the extent that McDowell Mountain has taken action relying on this consent.

SIGNATURE: _____DATE:_____

RELATIONSHIP if signed by another party: _____

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INFORMED CONSENT FOR TELEMEDICINE SERVICES

PATIENT NAME: _____DOB: _____

CONSENT FOR MCDOWELL MOUNTAIN PROVIDERS TO PROVIDE TELEMEDICINE SERVICES WHEN AVAILABLE

INTRODUCTION: Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The information bay be sued for diagnosis, therapy, follow-up and or education and may include any of the following: *Patient medical records * Medical images * live two way audio and or visual * Output data from medical devises

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging date and will include measures to safeguard the data and ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS: * Improved access to medical care by enabling a patient to remain in his or her home while accessing physicians care. * More efficient medical evaluation and management * Obtaining expertise of a distant specialist.

POSSIBLE RISKS: As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include but are not limited to: * in rare cases, information transmitted may not be sufficient (e.g. Poor resolution of images) to allow for appropriate medical decision making by the physician. * Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment. * In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. * In rare cases, a lack of access to complete medical records may result in adverse drug reactions or other judgment errors.

BY SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING: I understand that the laws that protect privacy and confidentiality of medical information apply to telemedicine and the confidentiality of medical information also apply to telemedicine and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities with out my consent.

1. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in thru course of my care at any time with out affecting my right to future care or treatment
2. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of the information for a reasonable fee.
3. I understand that a variety of alternative methods of medical care may be available to me and that I may choose one or more of these at any time. My practitioner has explained the alternatives to my satisfaction.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners to assist in my care.
5. I understand that it is my duty to inform my practitioner of electronic interactions regarding y care that I may have with other health care professionals.
6. I understand that I may expect the anticipated benefits from the use of telemedicine but no results can be guaranteed or assured.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided to me regarding telemedicine. All my questions have been answered to my satisfaction I hereby give my consent for the use of telemedicine in my care:

Signature: _____ Print: _____Date_____

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PATIENT NOTICE OF FINANCIAL POLICY

PATIENT: _____DOB: _____

Our office is committed to providing you with the best possible health care and we will be happy to discuss our professional fee with you. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy or your financial responsibility. All patients must complete our patient information forms before seeing the Doctor, Nurse Practitioner or Physician Assistant. It is important that you understand that you are responsible for all charges that may occur during your visit. In addition to paying for any insurance deductible or co-payment at the time of your visit, you may also be responsible for charges not covered by your insurance carrier> If your insurance denies a medical claim, the patient and or responsible party is ultimately responsible for timely payment of the account. All patients' balances are due with in 30 days of notifications.

FEES AND CHARGES:

_____ **I acknowledge** a credit card reversal (chargeback) will be subject to a $35.00 fee.

_____ **I acknowledge** a returned check fee will be a minimum of $35.00.

_____ **I acknowledge** that there is a $35.00 fee for completing all FMLA paperwork.

_____ **I acknowledge** there is a $50 administrative and copy fee for obtaining your medical records for your personal use. If your medical records are in storage there will be an additional $25.00 fee.

_____ **I acknowledge** there is a 24 hour notice required for cancellation of appointments. Missed appointments and appointments not cancelled within 24 hours will be subject to a $70 fee to be paid prior to your next visit.

_____ **I acknowledge** there is a 48 hour notice required if you are unable to keep ULTRASOUND, PROCEDURAL or URODYNAMIC appointments. These will be subject to a $100.00 fee.

_____ **I acknowledge** that there are products and services provided by McDowell Mountain Gynecology that are not covered by insurance and are on a cash pay basis. I am fully responsible when I agree to these services.

I have read the financial policy for the office and understand that I am ultimately responsible for all charges on my account. It is my financial responsibility to remit payment for any charges not covered by my insurance plan including but not limited to co-insurance, co-payments and deductibles**. I understand that co-payments for the office are due at the time of service.** I understand that refunds are only given if no account balance is due on my account and when my claims have been completely adjudicated. Furthermore, I understand once it has been determined a refund is due; it may take a minimum of 6 weeks**. I understand that obtaining services immediately prior to bankruptcy is considered fraud.** I understand that once my account is put into collections I will be responsible for any additional charges to collect any and all unpaid balances, including but not limited to collection agency and attorney fees. I understand that if I refuse to pay my bill, a collection fee of 30% of the amount due will be charged to my account.

Responsible Party's email:_____

Patient Signature: _____Date: _____

Employee Witness: _____Date: _____

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