NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I acknowledge that the Notice of Privacy Practices is available.

_____

Patient Signature

FINANCIAL POLICY

Thank you for choosing DIAGNOSTIC CENTER FOR WOMEN, LLC. The following is a statement of our Financial Policy.

PAYMENT IS DUE AT THE TIME OF SERVICE
ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT
WE ACCEPT: CASH, CHECK, VISA, MASTERCARD, DISCOVER , AMERICAN EXPRESS, AND CARE CREDIT.

PROOF OF INSURANCE: All patients must complete our patient information form. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We are in network with most major insurance carriers. However, it is the patient's responsibility to verify that we are a participating provider of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all co-payments, co-insurances and deductibles must be paid at time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

PRESCRIPTION/ORDERS: It is the patient's responsibility to obtain a prescription or order form from your physician. We will assist in obtaining such orders; however studies can only be preformed if order or prescription is on file. If we cannot obtain prescription or order your appointment will be rescheduled.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of services rendered..

NONCOVERED SERVICES: Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

RETURNED CHECKS: Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) along with a $50.00 NSF fee from the office.

COLLECTION POLICY: Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

I HAVE READ AND FULLY UNDERSTAND the Financial Policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth.

Patient Name: _____ Date: _____

Patient/Responsible Party Signature: _____