

DEKALB WOMEN'S SPECIALISTS

INFORMED CONSENT AND REQUEST FOR OFFICE VISIT

I, _____, acknowledge and understand that as a patient of Dekalb Women's Specialists, I can expect my office visit to include any combination of the following:

1. **Data Collection** – The office staff and provider (physician or nurse practitioner) will gather information regarding your reason for your visit and any other important information.
2. **Physical Examination** – this portion of your visit will usually include monitoring your blood pressure, weight, and height. We may also check your urine for problems, such as infection. Depending on your problem, a problem –specific physical examination will be performed by the provider and may include a pap smear and/or a pelvic exam.
3. **Blood work** – your provider may choose to refer you to another physician based on your problems.
4. **Referrals** – your provider may choose to refer you to another physician based on your problems.
5. **Additional procedures** – any further procedures (for example, biopsy or ultrasound), if needed, will be discussed by your provider and separate consent will be reviewed if necessary.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND / OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND IT CONTENTS, AND THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS, WHICH HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS THAT I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM.

I voluntarily consent to allow Dekalb Women's Specialists including physicians, nurses, and medical personnel, to perform the procedure listed above.

Signature of Person Giving Consent

Date / Time

Witness

Reason Patient Unable to Sign

DeKalb Women's Specialists

Date ___/___/___

PATIENT INFORMATION

Name: _____

Last Name
First Name
Middle Name
Maiden Name

Address: _____

Street
City & State
Zip

Birth date ___/___/___ Age ___ Martial Status S M D W SS# _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employed by: _____ How Long? _____ Occupation _____

Address _____

Street
City & State
Zip

Emergency Contact _____ Phone _____

Referred by _____ Phone _____

Spouse's Name _____ No. of Children _____

Driver's License # _____ State _____

INFORMATION ON PERSON RESPONSIBLE FOR BILL

* The guarantor is the person whose check is being deducted for insurance payments.

Guarantor Name _____

Last Name
First Name
Maiden Name

Address _____

Street
City & State
Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Employed by _____ How Long? _____ Occupation _____

SS# _____ Birth date ___/___/___ Relation to Patient _____

INSURANCE INFORMATION

Do you have insurance to cover the FEES for services rendered? ___ Yes ___ No

Name of Insured	Name of Insured
Primary Insurance	Secondary Insurance
Claims Address	Claims Address
Policy #	Policy #
Group # Effective Date	Group # Effective Date
Email Address:	

<p>I authorize the release of any medical information necessary to process this claim. Additionally, I request payment (if applicable) of any Medicare benefits either to myself or to the party who accepts assignment.</p> <p>Sign _____</p> <p>Date: ___/___/___</p>	<p>I authorize the release of any medical information necessary to process this claim. Additionally, I request payment (if applicable) of any Medicare benefits either to myself or to the party who accepts assignment.</p> <p>Sign _____</p> <p>Date: ___/___/___</p>
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PATIENT'S PRINTED NAME: _____

**DeKalb Women's Specialists
Financial Responsibility Policy**

I understand that I, _____, or my guardian _____, will be responsible for paying any fees not paid by my insurance company.

I also understand that I am responsible for understanding the terms of my insurance coverage and benefits (i.e. deductibles, coinsurances and copays). DeKalb Women's Specialists will assist you in the accurate filing of claims, but we can not change claims to benefit you. The providers of DeKalb Women's Specialists will perform services and lab work in accordance with YOUR health needs, and it is your responsibility to decline services and lab work that is not covered by your insurer. Once services are rendered, I agree to pay for them.

If I am unable to pay a balance in full, I will pay according to the payment plan arranged by DeKalb Women's Specialists. I will attend all scheduled meetings with my financial counselor and I understand that failure to follow financial policy will lead to my account being sent to collections and my dismissal from DeKalb Women's Specialists. Balances are to be paid at the times services are rendered or a plan can be arranged to pay on services prior to them being rendered.

I understand that if I do not adhere to the payment schedule as set forth that I will be subject to collections methods which can incur additional costs of up to 40% over my charges.

Most lab work is performed by an independent laboratory and I understand that I will be billed separately for those services. If I have questions about my labs I will address them to LabCorp or it's representative stationed in the office. I understand that DeKalb Women's Specialists can not waive fees for services that are rendered by LabCorp.

If I am a Medicaid recipient, I understand that if I should lose my eligibility or if I should change my CMO to any payer other than Peachstate Health Plan, then I shall pay for services rendered or be dismissed from the practice.

If I am not approved by SSI, Medicaid of GA Better Healthcare, I understand that all charges will be billed to me or my guardian.

I understand that there are fees for copying of medical records for my use and completing information on forms such as Disability and FLMA.

Patient Signature

Date

Guardian Signature

Date

Albert Scott, Jr., M.D.
Kathleen Johnson, M.D.

Kimberlee Coleman-Henderson, M.D.
Julianne Adams, M.D.
Stacy Reynolds, M.D.

PREGNANT PATIENTS ONLY

Dear Valued Patient Receiving Medicaid Assistance,

If you receive services in our office for which Medicaid or a Medicaid CMO (Peachstate, Wellcare or Amerigroup) will be billed, you **MUST** sign this acknowledgement stating that you have no additional coverage above and beyond Medicaid. Pursuant to the laws that authorize Medicaid, if you have private health insurance, this claim **MUST** be submitted to your private insurance first and then Medicaid secondarily. If your claim is submitted to Medicaid as the primary, **you are committing fraud.**

By signing this document, you, as the undersigned, swear or affirm under penalty of law that you have no private health insurance coverage. If you are not willing to sign this form, we will not be able to accept you as a patient.

I, _____, do hereby swear or affirm that I have no private health insurance coverage and that based upon my signature to this document, this office will be submitting the bills for my medical services to Medicaid. If I fail to provide any private insurance information, I may be reported to the State for further investigation.

Date

Signature

Printed Name



DeKalb
Women's
Specialists

404-508-2000

No-Show Policy Acknowledgement From

We make a courtesy call to all patients the day before an appointment and leave a message for patients we are unable to reach.

As you schedule your next appointment, please ensure that we have your updated phone number.

If you do not show up and do not call to cancel within 24 hours of your appointment, you will be charged a no-show fee of \$25.

DECATUR OFFICE
2675 N Decatur Road
Suite 512
Decatur, GA 30033

I have read and understand the above financial notice, and I understand my financial responsibility if I do not show and do not call to cancel within 24 hours of my appointment.

_____/_____/_____
PRINT NAME

STONECREST OFFICE
8052 Mall Parkway
Suite 202
Lithonia, GA 30038

SIGNATURE

DeKalb Women's Specialists
NOTICE OF PRIVACY PRACTICES

Effective Date: 4/15/03

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION
ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU
CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this notice, please contact Privacy Officer or designee.

WHO WILL FOLLOW THIS NOTICE.

This notice describes our practice's procedures and that of:

- ▶ Any health care professional authorized to enter information into your medical record.
- ▶ All departments and units of our practice.
- ▶ Any member of a volunteer group we allow to help you while you are in our practice.
- ▶ All employees, staff and other practice personnel.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION.

We understand that information about you and your health is personal. We are committed to protecting your health information. We create a record of the care and services you receive at our practice, as well as records regarding payment for those services. We need these records to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our practice doctors and/or personnel working for the practice.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights, and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and

- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- ▶ **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For instance, we may need to share information about your condition with another doctor if you have complications and need a specialist. Our practice also may share medical information about you in order to coordinate the different things you need, such as prescriptions and lab work.
- ▶ **For Payment.** We may use and disclose health information about you so that the treatment and services you receive at our practice may be billed, and that payment may be collected from you, an insurance company or another third party. For example, we may need to give your health plan information about services that you received at our practice so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- ▶ **For Health Care Operations.** We may use and disclose medical information about you for the practice's health care operations. These uses and disclosures are necessary to run our practice and to make sure that all patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services our practice should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, residents, and other practice personnel for review and training purposes. We may also disclose your information, in conducting or arranging other business activities of the practice. We may disclose information as part of a sale, transfer, merger or consolidation of our practice to another entity covered by the Privacy Rule. We may also combine the medical information we have with medical information from other facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.
- ▶ **Appointment Reminders.** We may disclose information, if necessary, to contact you to remind you about appointments.

- ▶ **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- ▶ **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- ▶ **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be informed about your condition and location.
- ▶ **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.
- ▶ **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS.

- ▶ **Research.** We may also do certain kinds of research using your records, but only if a legally authorized review board gives us permission to use your information and provided that the researcher says he/she will use safeguards to protect your information.
- ▶ **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- ▶ **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may use and disclose information to the Department of Veterans Affairs to determine whether you are eligible for certain benefits.
- ▶ **Workers' Compensation.** If applicable, we may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- ▶ **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
 - to report deaths;
 - to report reactions to medications or problems with products;
 - to notify people of recalls of products they may be using;
 - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
 - to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- ▶ **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with applicable civil rights laws.
- ▶ **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if we receive satisfactory assurances that the party seeking the information has made efforts to tell you about the request or to obtain an order protecting the information requested.
- ▶ **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
- In response to a court order, subpoena (after we attempt to notify you), warrant, summons or similar process;
 - To identify or locate a suspect, fugitive, material witness, or missing person;
 - About the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
 - About a death we believe may be the result of criminal conduct;
 - About criminal conduct at our offices; and
 - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- ▶ **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of our practice to funeral directors as necessary to carry out their duties.
- ▶ **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- ▶ **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

- ▶ **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes and other mental health records in certain cases.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer or designee. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed if the denial is made for certain reasons. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- ▶ **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our practice.

To request an amendment, your request must be made in writing and submitted to our Privacy Officer or designee. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- ▶ **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of certain disclosures we made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer or designee. Your request must state a time period which may not start more than six years in the past and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

- ▶ **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations purposes. You may also request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information to your spouse.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- ▶ **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate

your request if it is reasonable. Your request must specify how or where you wish to be contacted.

- ▶ **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice contact our Privacy Officer or designee at our address or visit our webpage at www.dekalbwomen.com.

CHANGES TO THIS NOTICE.

- ▶ We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our practice. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact *[insert the name, title, and phone number of the contact person of practice for handling complaints. This should be the same person or department listed on the first page as the contact for more information about this notice.]* All complaints must be submitted in writing.

You will not be penalized in any way for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

DeKalb Women's Specialists

RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by _____.

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name _____

Patient/Responsible Party Signature _____

Date _____