LOWCOUNTRY Women's Specialists
WE TAKE CARE OF YOU FOR LIFE

LCWS PATIENT ACKNOWLEDGEMENT OF BUSINESS PRACTICES

_____ (Initial) As a courtesy to our patients, our staff contact your insurance carrier in advance of your appointment for benefits verification, deductible status, and patient financial responsibility. Please note, the information provided is valid at that point in time. Any claims that may process after that date will affect any quotes provided to us. We provide our patients estimations given to us from your carrier which is based upon claims processed by your carrier at that time. Any additional services rendered that were not known at that time, will affect your patient out-of-pocket responsibility. This "estimate" is not a guarantee of benefits. I understand that according to my individual agreement with my insurance carrier, I am required to pay an applicable deductible, co-pay or co-insurance for covered services, as well as any balance for services not covered by my insurance plan, at the time of service.

_____ (Initial) Patients are responsible for all fees for services rendered, regardless of insurance coverage. Patient portions for services are due when rendered unless other arrangements have been made in advance. If this account is turned over for collection, the undersigned guarantor (parent or guardian if patient is a minor) agrees to pay collection and attorney's fees. Payments may be made in cash, check, Visa, MasterCard, Discover, and American Express.

_____ (Initial) Any returned check will incur a $35 fee and are further handled by Pay Alliance. Patients with account balances receive a monthly statement. Delinquent accounts are sent to an outside collection agency- Receivables Management Corporation for non-payment. Payment plans are available for accounts with balances greater than $200.00 and for no longer than 6 months. LCWS reserves the right to use the contact information provided in this form by you, the patient, to communicate information regarding your account, including attempts to collect on monies owed to LCWS. We reserve the right to provide your contact information to any third-party for the express purpose of collecting any amounts you may owe for services rendered. By signing this form, you agree that we may contact you by telephone at any telephone number associated with your account. Method of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, text message, as applicable.

_____ (Initial) LCWS currently participates in the Surescripts system. This allows for the electronic prescribing of medications, which provides a convenience to patients and physicians and reduces medication error. An additional portion of this service allows for the electronic receiving of medication information such as medications, dosages and prescriptions filled from participating pharmacies. This too, reduces error in medication entry into the medical record and provides your physician with an up-to-date medication profile. By initialing below, you give LCWS permission to access your information to receive this information electronically for your medical record.

_____ (Initial) I understand I may be charged a $20.00 fee for any forms or paperwork to be completed by the physician (e.g., Family & Medical Leave Act forms, Medical Necessity Forms, Department of Driver Services Forms, Disability Forms, Life Insurance forms, etc). Your insurance company will not cover this fee.

_____ (Initial) LCWS participates in research studies and patients who meet the qualifications of the study may be asked if they are interested in enrolling or participating. If yes, a separate consent will be signed at that time and the patient will receive an explanation of the study.

NO SHOWS/SURGERY CANCELLATIONS

_____ (Initial) A representative calls our patients in advance with benefits and estimated patient costs. Patients also receive text message appointment reminders for their upcoming appointment. Please give 24 hrs notice if you are unable to keep our office appointment and at least 48 hrs if you are canceling a surgical procedure. Patients who do not show up for an office appointment will be charged $75. If surgery is canceled less than 48 hrs prior to the procedure, patients are charged $200 for unused operating room and physician lost revenue.

INSURANCE AUTHORIZATION AND ASSIGNMENT

_____ (Initial) I understand that I am to IMMEDIATELY notify Lowcountry Women's Specialists if ANY changes occur in my medical insurance. I also agree to provide information for all insurance plans I carry (Medicaid, secondary insurance, Medicare, etc). Photocopies or original insurance cards are required. We cannot accept pictures of ID cards on cell phones because we cannot scan the image into our EMR.

_____ (Initial) I understand and agree that Lowcountry Women's Specialists may use and disclose protected health information (PHI) (including but not limited to name, address, health history, symptoms, examination, test results, diagnosis, and treatment) for continuum of treatment, reimbursement, or healthcare operations.

I hereby authorize Lowcountry Women's Specialists, PA. to furnish information to insurance carriers concerning my illness and treatments for purposes of reimbursement for services rendered and for prior authorization of treatment or devices. I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance. I certify that the above information is true and correct.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT.

_____ _____

Signature Date

GENERAL CONSENT TO TREATMENT

I authorize the performance of physical examination, ultrasound, laboratory and other routine diagnostic procedures and treatments as my physician considers to be necessary or appropriate for the purpose of my visit and diagnosis of my condition. I understand that the nature of and the need for additional procedures, diagnostic testing, and treatment will be explained to me beforehand, and that I am free to refuse anyone or all diagnostic tests, procedures, or treatments, if I so choose. I understand that I should ask questions regarding any aspect of my diagnosis or treatment for which I do not understand.

_____ _____

Signature Date