SOUTHWEST GEORGIA
OBSTETRICS | GYNECOLOGY
Celebrating Women's Health

PRACTICE PRIVACY NOTICE

AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information I have reported with regards to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier. I may revoke my consent in writing at any time except to the extent that the practice has already made disclosures in reliance upon consent.

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical and surgical benefits which are payable to me under the terms of my insurance policy to be paid directly to Southwest Georgia OB/GYN, for services rendered.

A photo static, facsimile, and/or electronic copy of this form may be used in the place of the original. This authorization and assignment is to serve as a lifetime authorization, remaining in force until revoked in writing by me.

NOTICE OF PRIVACY ACKNOWLEDGMENT

All patient records remain the property of Southwest Georgia OB/GYN. Records are centralized and may be accessed by any Southwest Georgia OB/GYN provider or employee, as a necessary function of their role within our practice. Southwest Georgia OB/GYN does not release patient records, including billing, scheduling, and medical information, unless required to do so by international, federal, state or local law, or necessary for payment from the insurance carrier, treatment, healthcare operations or if the patient has signed a medical release form. We respect the right of patient confidentiality. Southwest Georgia OB/GYN complies with all HIPPA and other federal and state privacy regulations. A Notice of Privacy Practices for Southwest Georgia OB/GYN is available upon request. Southwest Georgia OB/GYN reserves the right to revise its Notice of Privacy Policies at any time. I acknowledge, by signature below, that I have been made aware of my right to review or obtain a copy of the Notice of Privacy Practices for Southwest Georgia OB/GYN.

PHOTOGRAPHS/ANNOUNCEMENT POSTING

I hereby authorize display of photographs and all various type of announcements that I submit and understand that they will be seen by everyone who visits Southwest Georgia OB/GYN. I understand that if I do not want the items displayed, I will not submit them to Southwest Georgia OB/GYN.

FINANCIAL AGREEMENT

I hereby assume financial responsibility and agree to make payment in full to Southwest Georgia OB/GYN for all charges for services or medical supplies furnished to me, whether this be my deductible, co-insurance, co-pay or otherwise allowable amount determined by my insurance company. This also includes services not authorized or paid for by my insurance carrier. I understand that all co-payments, co-insurance and deductible amounts, as determined by my insurance carrier, are to be paid at the time of service. In the unfortunate event my account balance becomes delinquent and is referred to a collection agency or attorney, I shall be responsible for the costs of collections, also to include our court costs. A fee of $35.00 will be charged for any check not honored by my bank.

I understand that it is my responsibility to inform Southwest Georgia OB/GYN of any changes to my address, phone numbers and insurance coverage.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Signature of Southwest Georgia OB/GYN Date

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Patient HIPAA acknowledgement and designation disclosure form

I. Authorization to Release Medical/Billing Information:

I authorize Southwest Georgia OB/GYN to release medical, scheduling and billing information to the following individual(s). I understand that if no person is listed, no information will be given to anyone on my behalf.

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

II. Authorization to Receive Confidential Communications:

I hereby request that Southwest Georgia OB/GYN make all communications to me by the following means that I have listed below.

Primary Contact Number: _____

[ ] Ok to leave message with detail information [ ] Leave message with appointment information

[ ] Leave message with call back numbers only

[ ] OK to E-mail me at: _____

_____ _____

Signature of Patient Date