





## Central Carolina Obstetrics & Gynecology

A Division of Piedmont Healthcare for Women

It is the policy of Piedmont Healthcare for Women, PA Central Carolina OB/GYN, division, to collect payment at the time services are rendered. If you have insurance with which we are contracted, applicable co-payments and/or co-insurance amounts are due at the time of service. The fees of this office are not based on the amount insurance will pay. The amount approved for payment on a particular procedure by your insurance company may be more or less than the fee charged by Piedmont Healthcare for Women, PA Central Carolina Obstetrics and Gynecology, division.

I understand that my medical insurance is an agreement between me and my insurance company to pay a specific amount for medical care. I also understand that full payment for my treatment remains exclusive financial responsibility, including charges not covered by my insurance carrier. I further understand that payment in full is due sixty (60) days after a claim has been submitted to my insurance carrier on my behalf. In addition, I understand that if my insurance requires pre-admission certification it will primarily be my responsibility to make sure this requirement is met.

I understand and agree to all statements contained herein and further understand that my failure to comply with this agreement may subject me to collection activity. If collection is pursued, I understand that I may be held responsible for the cost of recovery of bad debts, including collection and attorney fees.

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Signature of Patient or Responsible Party if Minor

I hereby authorize Piedmont Healthcare for Women, PA Central Carolina Obstetrics and Gynecology, division to furnish information to my insurance company regarding my examination(s). I also assign payment directly to Piedmont Healthcare for Women, PA Central Carolina Obstetrics and Gynecology, division for surgical and medical benefits.

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Signature of Patient or Responsible Party if Minor

***Please note at least 24 hour advance notice is required for the cancellation of appointments. You may be required to pay an office visit charge if you do not cancel within 24 hours of your scheduled appointment time., (Please call Friday if a monday appointment will not be kept.)***

***In addition, if more than two (2) appointments are missed, you may be terminated as a patient from the practice.***

PIEDMONT HEALTHCARE FOR WOMEN

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize PIEDMONT HEALTHCARE FOR WOMEN to use and/or disclose certain protected health information (PHI) about me.

\_\_\_\_\_.

This authorization permits PIEDMONT HEALTHCARE FOR WOMEN to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed such as date(s), of service, types of service, level of detail to be released, origin of information, etc.):

\_\_\_\_\_  
\_\_\_\_\_

The information will be used or disclosed for the following purpose:

\_\_\_\_\_.

If requested by the patient, purpose may be listed as “at the request of the individual, “  
The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on \_\_\_\_\_.

The Practice will \_\_\_ will not \_\_\_ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from PIEDMONT HEALTHCARE FOR WOMEN. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it

may be subject to redisclosure by the recipient and my no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Central Carolina OB/GYN  
301 East Wendover Avenue, Suite 400  
Greensboro, NC 27401

Signed by: \_\_\_\_\_

Signature of Patient or Legal Guardian

Relationship to Patient

\_\_\_\_\_

Patient's Name

\_\_\_\_\_

Date

\_\_\_\_\_

Print Name of Patient or Legal Guardian

*PATIENT GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION*

## PIEDMONT HEALTHCARE FOR WOMEN

### **Patient Consent for use and Disclosure of Protected Health Information**

I hereby give my consent for PIEDMONT HEALTHCARE FOR WOMEN to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). PIEDMONT HEALTHCARE FOR WOMEN's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. PIEDMONT HEALTHCARE FOR WOMEN reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to PIEDMONT HEALTHCARE FOR WOMEN Privacy officer at 301 East Wendover Avenue, Suite 400, Greensboro, NC, 27401 (286-6565).

With this consent, PIEDMONT HEALTHCARE FOR WOMEN may call my home or other alternative location and leave a message on voice mail or in person in reference to any items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, PIEDMONT HEALTHCARE FOR WOMEN may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked (Personal and Confidential.)

With this consent, PIEDMONT HEALTHCARE FOR WOMEN may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that

PIEDMONT HEALTHCARE FOR WOMEN restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to PIEDMONT HEALTHCARE FOR WOMEN'S use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, PIEDMONT HEALTHCARE FOR WOMEN may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Patient's Name

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Date

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Print Name of Patient or Legal Guardian

PIEDMONT HEALTHCARE FOR WOMEN

Receipt of Notice of Privacy Practices  
Written Acknowledgment Form.

I, \_\_\_\_\_, have received a copy of PIEDMONT  
HEALTHCARE FOR WOMEN'S Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date