Patient Name: _____

Patient Date of Birth: _____

Patient Financial Consent: Triangle Premier Women's Health (TPWH) is contracted with various health insurance plans, including but not limited to Medicare, Medicaid, and other commercial insurance plans. As a courtesy, TPWH will file a claim on my behalf for the services I receive to the insurance company I provide to TPWH to place on file. If TPWH is not contracted with my medical insurance, I am responsible to pay in full at the time service is rendered. I understand I am considered self-pay if I do not have active coverage and I am responsible for all charges incurred at the time of service.

It is my responsibility to understand my insurance coverage and limitations. I understand that I am liable for any out-of-pocket expenses including but not limited to deductibles, co-insurances, co-pay's and/or services not covered by my insurance plan. Most of TPWH's contracted insurances do not require me to have a referral to be treated by an OB-GYN. However, some insurance plans do require a prior-authorization or a referral from my Primary Care Physician (PCP). TPWH will help obtain my prior authorization or referral; however, I am responsible to ensure the required authorization is provided in advance. If this authorization/referral is not on file upon check-in, TPWH may need to reschedule my appointment.

Depending on my insurance coverage at the time of my visit to TPWH, I may be required to make a deposit on my account before seeing my clinician. Deposits will be applied toward charges incurred for the services I received that may not be fully covered by my insurance plan. I understand that there may be additional charges if I receive an ultrasound, supplies, labs, or if more complex services are required for treatment. Some services require payment with cash or CC/Debit Card only (No checks). Medicaid is only filed as a secondary insurance for OB services during pregnancy and the postpartum period.

It is my responsibility to ensure that all services rendered by TPWH on my behalf are paid in full within thirty (30) days of the statement date. Please note that, with the exception of errors, TPWH does not change the reason for my services (billing codes) once they have been submitted to my insurance company. I understand that I am ultimately responsible for the payment of my medical bill. If it becomes necessary, TPWH may utilize a Third Party to assist in collecting any outstanding debt I have incurred.

I am consenting those payments from Medicare, Medicaid, Government and any other insurance or third-party benefits are to be made on my behalf, and/or on behalf of all members covered under my insurance plan, directly to TPWH for services provided. I am authorizing TPWH to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims/or to verify plan benefits in accordance with HIPAA health information standards.

Consent to Treat: I (or my personal representative on behalf of me) consent to receive health care, including routine diagnostic procedures, examination, contraceptive methods and other health services provided by TPWH, and its duly authorized agents and staff. It is my choice to receive healthcare services provided by TPWH. I can change my mind about receiving medical services at TPWH at any time. I understand that the practice of medicine and surgery and the rendering of health care is not an exact science and that no guarantees have been made regarding the results of treatments, examinations or other health services rendered by TPWH. I understand that a clinician is available to answer any questions I may have and I should ask questions about anything I do not understand prior to receiving any treatment. I understand that for certain sexually transmitted infections, reporting of positive results to public health agencies is required by law. I agree to be treated by a nurse practitioner, physician assistant and/or certified nurse midwife if the medical doctor is unavailable. I understand that if I change my mind about this decision, I can do so by requesting to only see a physician.

Telecom Agreement: By signing this form, I agree that TPWH (its affiliates, and those acting on its/their behalf) may call, text or email. The types of calls, texts or emails I may receive include those concerning my healthcare care, payments, scheduling, reminders, prescriptions, or practice announcements. By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my healthcare clinician to employ a third-party automated outreach and messaging system to use my personal information, the name of my care clinician, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other health care related function. Such automated system may include an artificial or prerecorded voice. I also authorize my healthcare clinician to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving, when necessary, multiple messages per day from my healthcare clinician. I consent to allow detailed messages to be left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided. TPWH respects my privacy and will not share my contact information other than for the purposes outlined above. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preferences at any time.

Surgery: If my clinician recommends surgery, I will be contacted by TPWH surgery coordinator within 2-4 business days. The surgery coordinator will be able to answer specific questions about the surgery scheduling process, discuss paperwork and test involved. The surgery coordinator will ensure that all pre-certification/authorization requirements are met if indicated by my insurance carrier. The surgery coordinator will also verify coverage and will request a pre-surgical deposit, the amount of which depends on my insurance coverage. A cost estimate which outlines my financial responsibility, based on benefit levels and coverage of my insurance plan, will be explained to me. The surgical deposit is collected via Cash or Credit Card/Debit Card only.

Medications: I authorize TPWH to import my medication fill history from my pharmacies through a third-party application (SureScripts). I understand that I will need to contact my preferred pharmacy to request medication refills. Once the request has been received, refills will be completed within 3 business days.

Anatomic Pathology Services: In compliance with the NC General assembly Session 2005, h.b. 636, we hereby disclose to you our markup of anatomic pathology services to self-pay patients. The name of the licenses laboratory in which we utilize to perform our anatomical pathology services, such as pap smear, HPV and biopsy is Ariana Dx Services (formerly Eastern Carolina Pathology). There is a separate itemized disclosure statement available to you upon your request.

Appointment Policy: TPWH provides appointment reminders and access to my patient portal as methods for maintaining my appointment dates and times. I understand that it is my responsibility to ensure that I attend appointments scheduled. It is my responsibility to cancel and reschedule any appointments that I am unable to attend. Appointments included, but are not limited to, blood work, NST, Ultrasounds, in office procedures, injections, visits with the clinician. If I am consistently non-compliant, I understand that I may be dismissed from the practice.

Completion of Forms: I understand that it is my responsibility to submit forms that I may need to provide to my employer or disability company, such as FMLA and Disability Forms, and these forms must have my portion of patient related information fully completed prior to presenting to TPWH to be filled out. I understand that completion of such forms may take 3-5 business days and therefore I should submit my forms in a timely manner. There is a $10 fee for the completion of forms that I must pay prior to forms being returned to me. It is my responsibility to pick up my completed forms and route them appropriately, TPWH is not responsible for ensuring my forms are returned to other entities.

Notice of Privacy Practices: Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), TPWH makes available a copy of its Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information.

I, or my legal representative, certify that I have read this document, it has been fully explained to me and that I understand its contents, and I hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

_____ _____

Signature of Patient/Legal Guardian/Authorized Representative | Relationship to Patient

_____ _____

Witness Signature | Date/Time of Signing Consent