WOMENS HEALTHCARE GOUP OF PA
WOMEN FOR WOMEN DIVISION

HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read/received a copy of the *HIPAA NOTICE OF PRIVACY PRACTICES*, as posted at Women for Women Division of WHCGPA.

Patient Name: _____
Patient Signature: _____
Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION DOES NOT EXPIRE UNLESS OTHERWISE REQUESTED BY PATIENT

By signing below, I authorize the disclosure of my Protected Health Information (including HIV/AIDS related information if any) to the person(s) listed below:

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

Patient Signature: _____ Date: _____

AUTHORIZATION TO LEAVE PROTECTED HEALTH INFORMATION ON ANSWERING MACHINE

By signing below, I authorize Women for Women Division to leave my Protected Health Information (including, but not limited to results, prescriptions and appointments) on my answering machine at this number: _____

Patient Signature: _____ Date: _____

ACCEPTANCE OF RESPONSIBILITY FOR PAYMENT

I accept responsibility for payment of all charges for services rendered during the course of my treatment at Women for Women Division, not covered by my primary insurance, secondary insurance, including charges for missed appointments/no-shows. I also acknowledge that Women for Women Division does not participate with any Medicaid or Medical Assistance programs or policies. I authorize Women for Women Division to release all information required by my insurance carriers for process of all claims. I further authorize assignment of benefits to be paid to Women for Women Division.

Patient Signature: _____ Date: _____