Women First
MARGIE CORNEY, MD
OB/GYN & ASSOCIATES

Notice of Privacy Practices

In accordance with HIPAA federal regulations, this establishment will not disclose any information about you or your personal health, without your permission. All information received while a patient (and if/when you decline to be a patient no longer) will be kept confidential.

Patient Consent for Use and Disclosure of Protected Health Information

By signing this form, you consent to the use and disclosure of your protected health information by our staff, and our business associated ***strictly for the purpose of treatment, payment and health care operations.***

You acknowledge you have had an opportunity to review our ***Notice of Privacy Practices*** prior to signing this consent. We encourage you to review our ***Notice of Privacy Practices*** carefully. It provides more detail on how we may use and disclose of your information. The ***Notice of Privacy Practices*** may change. A current copy may be requested when you are being seen as a patient, by contacting our office manager.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing; however, we reserve the right to deny your request. If we grant your request, we are bound by the terms of agreement.

You may also revoke this consent in writing; however, information on any treatment/service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment or health care operations. Refer to the ***Notice of Privacy Practices*** for further information.

By signing this form, I grant my consent for the practice to use and disclose my protected health information ***for the purposes of treatment, payment and health care operations.***

PATIENT SIGNATURE ____ DATE: ____________________________

PATIENT'S NAME (PLEASE PRINT) ____

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PROGRAM COST

This establishment does participate with **most** insurance plans. The cost of food products will **NOT** be billed to your insurance and **must be paid for weekly.**

We strive to make weight loss affordable. We offer a combined insurance/self-pay model for our Medical Weight Loss Program. We bill your insurance for covered benefits whenever possible in order to lessen out of pocket costs and reduce self-pay patient responsibilities. For **Self-Pay Patients,** those without insurance or whose insurance benefits does not cover preventive counseling for obesity or weight reduction, we have self-pay rates available for all products and services. We offer **weekly or bi weekly** payment plans. **Food products may not be included in the payment plan and must be paid for 2 weeks in advance. Final payment must be made prior to or at the 15th weekly office visit.**

To help you understand our pricing model, here are some examples of potential covered and non-covered benefits.

For insured patients, covered benefits could include:

- Weekly office visits with co pay
- Physician office visits with co pay
- Lab work

Self-pay or out-of-pocket expenses (for Insured and Non-insured Patients) include:

- Food and beverage
- Electrocardiogram test
- Multivitamins and Supplements

Rates for self-pay patients for services and products are as listed:

- **Program Cost $875.00**

The program cost includes:

- Your initial comprehensive health assessment with a doctor
- Weekly behavior modification sessions for 16 weeks
- Medical supervision by a doctor
- 1 set of Lab work
- Periodic electrocardiogram tests as warranted
- **Food Products**
  - 800 calories diet $60.00 weekly
  - 1000-1500 calories diet $48.00 weekly

Payment Plans

- **Weekly**
  - 16 weekly payments
  - 8 bi weekly food cost payments
- **Bi-weekly**
  - 8 bi weekly payments
  - 8 bi weekly food cost payments