Center For Women's Health

Offices at Cranbrook ▪ 10111 East 21st Street North ▪ Suite 301 ▪ Wichita, KS 67206
316-634-0060 ▪ 316-634-0050 (fax) ▪ cwhwichita.com

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

I have received the Notice of Privacy Practices of the Center For Women's Health, and consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for the professional services rendered to me and internal purposes such as quality improvement and how I can get access to this information.

Patients who carry healthcare insurance should remember that professional services are rendered to and charged to the patient and *not* to the insurance company. You will receive a statement each month if your account has a balance due that is your responsibility. Payment should be made upon receipt of the statement.

This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed benefit/claim. You are also responsible for paying your co-payment at the time of each visit. Payment of your account must be made within the limits of our office credit policy. If for any reason, your account is referred to our collection agency, you will be responsible for all collection costs.

Patients on Medicare, HMOs, PPOs or Medicaid will have their claims billed directly to the insurance carriers. If a carrier denies coverage, you will be responsible for the account. As a patient of Center For Women's Health, your signature is required below as acceptance of our policies and acknowledgment that you have been advised of our policies.

In addition, your signature will serve as authorization to release medical and account information to your insurance as required to process your medical claim. Your signature also denotes that you recognize and accept full responsibility for all professional services rendered and further authorize the insurance carrier to pay benefits directly to the physician if a balance is due.

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SIGNATURE OF PATIENT **DATE**

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SIGNATURE OF PARENT/GUARDIAN **DATE**