Gresham Women's Healthcare, P.C.

AUTHORIZATION
TO USE/DISCLOSE HEALTH INFORMATION

I authorize:____

____

(Name, Address phone and fax number of clinic or provider)

to use and disclose a copy of the specific health and medical information described below regarding:

____________________________ ________________

(Name of patient) *(date of birth)*

consisting of: ____

____

(Describe information to be used/disclosed)

TO / FROM : Gresham Women's Healthcare, P.C. 2150 NE Division St. Ste. 202 Gresham, OR 97030
Phone: (503)667-4545 Fax: (503)666-3298

for the purpose of: ____

(Describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose.)

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party; or
(2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to Gresham Women's Healthcare 2150 NE Division Ste. 202 Gresham, OR 97030; that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

This Authorization will expire on the earlier of ________________ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By:________________________________ Date:______________
(Patient)

\- OR -

By:________________________________ Date:______________
(Patient representative)

Description of Representative's Authority:________________________________

Office Policy & Assignment of Insurance Benefits

Annual

This Office Policy is designed to answer some questions you may have about our clinic.
To speak to a doctor, medical assistant, or schedule an appointment, call: **503-667-4545**.

New Patients

- Please bring your completed registration forms with you along with your insurance card. If you have been referred to us by another doctor's office, be sure to arrange to have all medical records and diagnostic reports available at your visit. Also, bring a list of medications you are currently taking. This will allow the doctor to better serve you.
- Patients arriving 10 minutes late to their appointment will be rescheduled to another time as a courtesy to other patients.
- If you do not have insurance, a $200.00 deposit for Gynecology services and a $500.00 deposit for new OB services is required at the time of registration. If you are unable to pay the deposit, we will reschedule your appointment to a time when you will be able to make the deposit. If you wish to pay for your visit **in full** at the time of service, we are happy to offer you a 20% discount. No discount will be applied to balances that we have to bill you for. We accept VISA and Mastercard.
- If your insurance plan requires a co-payment, be prepared to pay it at registration time. If you cannot pay your co-pay, we will reschedule your appointment to another time when you will be able to make the co-payment or if you request we bill you, we will charge a $20.00 billing fee.
- Balances that are not covered by insurance are due within 30 days of the initial billing unless satisfactory arrangements have been made with our billing office. Delinquent accounts will be considered for an independent collection agency or small claims court, in which case you will assume the full responsibility for collection costs, including any attorney and/or court fees. There will also be a $75.00 processing fee on all accounts sent to collections.
- If your insurance plan requires a referral to be seen by a specialist, it is your responsibility to obtain that from your Primary Care Physician. Should no referral be on record at the time of your visit, you will be asked to sign a referral waiver if you still want to see the doctor. By signing this, you will be accepting responsibility for all charges not paid by your insurance for lack of prior authorization.

Cancellation of Appointment

If you find it necessary to cancel your appointment, we request 24 hour notice so that your time may be given to someone else.

Checks Returned for Insufficient Funds

It is our clinic's policy to charge all patients a $25.00 fee for checks that are returned unpaid by the bank. Until a good credit history can be established, all further payments must be in cash or VISA/Mastercard.

Prescription Refills

- **ANTICIPATE!** Requests for prescription refills must come in during office hours only. Our doctors do not routinely write prescriptions during evenings or weekends because your medical records are not available.
- When you need a refill of your medication prescribed by our doctors, call your pharmacy even if you have no refills left. The pharmacy will contact us for an authorization to fill your medication. We need 24-48 hours to process the pharmacy's authorization request, so please plan your refill requests accordingly.

Hospital Affiliations

All our doctors do deliveries and surgeries at Legacy Mount Hood Medical Center. Only Dr. Yanke does deliveries and surgeries at Portland Adventist Hospital.

Disability Forms

Our doctors will gladly fill our your FMLA forms with no charge. However, for disability insurance claim forms, there will be a $20.00 charge for our doctors to fill them out. Be sure to fill out your portion first, then we will send or fax them to your disability company for you. Plan on allowing 24-48 hours for these to be filled out.

Acknowledgement and Consent

I understand that Gresham Women's Healthcare, P.C. (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- remind me of appointments;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privace Practices. I also understand that a copy of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above, and that I have received a copy of the Notice of Privacy Practices.