Comprehensive OBGYN Care

A division of Southern New England Women's Health, LLC

A Michael Coppa M.D   Jeiny Zapata APRN

Patient Care Agreement and Release

I. Release of Information for Billing Purposes

I agree that Comprehensive OBGYN Care will release to and receive from my insurer(s), other payers or other persons as necessary for billing and related purposes, at reasonable times and in accordance with current policies and procedures, any information which may be needed for billing, collection or payment of claims for services provided.

This information may include my identity, diagnosis, prognosis, and treatment for physical illness or injury, surgical procedures, progress notes, and all other information contained in patient care records to the extent that such records are needed for billing or collection of benefits due me from any payer. I understand that I have the right, upon request, to inspect and receive a copy of all such records being disclosed.

II. Assignment of Benefits

In consideration for the care provided by Comprehensive OBGYN Care, I authorize payment of medical benefits directly to Comprehensive OBGYN Care from any third-party insurance, plan, or entity, covering such expenses.

If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made on my behalf to Comprehensive OBGYN Care for any and all care. I agree that these benefits otherwise payable to me shall be paid directly to Comprehensive OBGYN Care and that this agreement cannot be revoked without my and Comprehensive OBGYN Care's consent.

If I receive payment directly from my insurance company, it is my responsibility to forward it to Comprehensive OBGYN Care for payment within 30 days of receipt.

III. Financial Agreement

Comprehensive OBGYN Care will collect co-payments, co-insurances, as well as outstanding balances and deductible amounts that will be assigned against your visit, at check in. If you are scheduled for surgery, Comprehensive OBGYN Care will estimate your deductible, co-insurance, or co-payment and this amount will be due prior to your surgery. Comprehensive OBGYN Care reserves the right to cancel or postpone surgery in the event of non-payment.

If care is determined to be a benefit not covered by insurance or Medicare, including serviced deemed experimental or investigational, I will be responsible to Comprehensive OBGYN Care for payment of the entire bill. If I am a Medicare beneficiary, I understand that I will receive notice that the care will not be covered. If, following this notification, I choose to receive care I will be responsible to Comprehensive OBGYN Care for payment of the entire bill. I agree that, should the amount covered by insurance or Medicare be insufficient to cover the entire Comprehensive OBGYN Care expense, I will be responsible for the payment of the difference. It is further agreed that credit balances resulting from payments from me or other sources may be applied to any account owed Comprehensive OBGYN Care by the same guarantor (me or my family). I agree to pay for the charges not covered by this assignment, included but not limited to co-payments, co-insurance and deductible charges, in accordance with Comprehensive OBGYN Care's regular rates and terms as applicable.

IV. Referrals

I understand that this is my responsibility to procure a referral from my PCP, when required by my insurance plan, prior to seeking services from Comprehensive OBGYN Care. If I choose to receive services without prior authorization, I acknowledge that I will be responsible for payment at the time services are rendered.

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V. Consent to Obtain Medication History

By signing this consent form, I agree that Comprehensive OBGYN Care may request and use my medication history, including current/past medications, from other healthcare providers or third-party pharmacy benefits manager for treatment purposes.

VI. Telephone Consumer Protection Act

As a component of my care, I understand and agree that Comprehensive OBGYN Care, it's providers or agents, including debt collectors, may contact me using automated calls, emails and text messaging sent to my landline and mobile device. These communications may notify me of upcoming appointments, test results, outstanding balances, or any other communication from the medical group.

VII. Notice of Privacy Practices Acknowledgement

By signing this form, I acknowledge that Comprehensive OBGYN Care has made the Health Insurance Portability and Accountability Act (HIPPA) notice effective April 14,2006 available to me on the date indicated below

- How Comprehensive OBGYN Care uses and discloses protected health information
- My privacy rights with regard to my protected health information
- Comprehensive OBGYN Care obligations to me concerning use and disclosure of protected health information

VIII. Notice Show Policy

By signing this document, I understand and will abide by the policy that Comprehensive OBGYN Care has for missed appointments. The No Show Policy encompasses that if a patient needs to reschedule or cancel a scheduled appointment, the patient is responsible to do so with at least 24-hour notice. If you, the patient, do not give a 24-hour notice or if you do not show up to your scheduled appointment, you are subject to charge a $50.00 No Show fee for a missed appointment or procedure.

Document Acknowledgement

I certify that I have read and understand the foregoing Patient Care Agreement and Release and that I am competent and authorized to execute this document. I understand that I am not entitled to make any changes or alterations to this legal non-negotiable document. I will notify Comprehensive OBGYN Care should my insurance coverage (including eligibility for Medicare or Medicaid), home address or other contact information change.

______________________________ ___________ _________
Patient/legal representative (print) Relationship Date

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Patient/legal representative signature