WOMEN'S EXECUTIVE HEALTHCARE, P.C.
Drina A. Northam, M.D.
A Division of Mid-Atlantic Women's Care, PLC
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PATIENT RESPONSIBILITY AND FINANCIAL AGREEMENT

AS A PATIENT OF WOMEN'S EXECUTIVE HEALTHCARE PC, I AGREE TO THE FOLLOWING:

1. **Medical Treatment Risks**: I acknowledge that all medical treatment involves some risks and that no guarantee can be given regarding the outcome. _____ **INITIAL**

2. **Release of Prescription History:** I authorize any physician who is treating me on behalf of Women's Executive Healthcare to request and receive any and all information regarding my medication history, including information maintained by the Virginia Prescription Monitoring Program. _____**INITIAL**

3. **All Payments Due at Time of Service:** Women's Executive Healthcare PC, as a courtesy to our Patients, will bill most insurance companies. I understand I am responsible for all co-pays, deductible, cost shares and non-covered services. By signing this agreement, I accept full responsibility of all Women's Executive Healthcare PC charges. If the account becomes delinquent, the undersigned agrees to be responsible for collection agency and/or attorney fees in the amount of 33 1/3%. I may also be responsible for court costs and litigation costs associated with any necessary collection procedures brought about by Women's Executive Healthcare PC, Mid-Atlantic Women's Care, that be necessary. Moreover, I authorize Women's Executive Healthcare PC to apply any overpayment from another Mid-Atlantic Women's Care medical bill to any other accounts owed by the Patient to Women's Executive Healthcare PC as a result of any prior treatments or admissions. _____**INITIAL**

4. **Multiple Bills:** I understand while I am receiving medical treatment at Women's Executive Healthcare PC, that I may receive a separate bill from a healthcare provider and/or laboratory other than a bill from the office listed above. For example, I may receive a separate bill from a laboratory, radiologist, pathologist and other providers. I agree to pay any outside bills received to the extent that it is not paid by my insurance. _____**INITIAL**

5. **Disclosure of Medical Information and Assignment of Benefits:** I authorize Women's Executive Healthcare to share my medical information and medical insurance company and third party payers. I also assign the benefit payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare or Medicaid for payment. _____**INITIAL**

6. **No-Show Policy:** If for any reason you are unable to keep your appointment, please call our office to reschedule or cancel at least 24 hours in advance, so that someone else may benefit from the appointment slot. I understand failure to call at least 24 hours in advance will result in a $30.00 no show fee, which is not covered by my insurance. I understand that after three missed appointments without calling to cancel, Women's Executive Healthcare PC will not offer any additional appointments and my care must be transferred to another practice. Our office will provide care for any necessary medical problem that may arise within 30 days, or you may seek care at an emergency department of a hospital. Once you have selected another physician, please sign a medical release form and contact the office so we may forward your medical records. _____**INITIAL**

7. **Forms:** There will be a $10.00 fee for completion of all forms for disability, employers, etc. Please have your portion of the form filled out and signed before leaving them at the office. Please allow 7 to 10 business days for completion. _____**INITIAL**

8. **Returned Checks:** There will be a $35.00 fee from our office if a check is returned to us for non-sufficient funds. _____**INITIAL**

9. **Confidentiality/Visitor Policy:** Due to patient confidentiality, we ask that you have any family members or friends wait in the lobby while you are being worked up by the nurses. Once this is finished, they may accompany you to the exam room. Due to limited reception area space, we ask that you bring no more than two guests (children under the age of twelve are not permitted) to your appointments. For ultrasounds please bring no more than two adult guests. _____**INITIAL**

10. **Affiliation with Mid-Atlantic Women's Care, Inc.:** We cannot be your provider if you have ever been dismissed from or involved in a legal matter with any other Mid-Atlantic Woman's Care, Inc. OB/GYN practices. _____**INITIAL**

This section pertains to PREGNANT patients ONLY

This practice **ONLY DELIVERS AT MARY IMMACULATE HOSPITAL** _____**INITIAL**

Sickness and work excuses during your pregnancy: A normal pregnancy is not a disability that would entitle you to miss work. If you are sick and need a work note, please call the office for an appointment, we will not back-date any work excuses. _____**INITIAL**

Virginia Birth Injury Program: Our providers participate in the Virginia Birth-Related Neurological Injury Compensation Program. This program provides benefits for the children who have a qualifying both-related neurological injury in a "no fault" approach. If you would like more information on this program, please ask our nurses for a copy of the brochure 'A Lifetime of Help". _____**INITIAL**

EACH PARTY TO THIS AGREEMENT ACKNOWLEDGES THAT THEY HAVE READ AND FULLY UNDERSTAND THE MEANING AND CONSEQUENCES OF EACH TERM AND PROVISION OF THIS AGREEMENT.

_____ _____

Patient or Responsible Party Signature | Relationship to Patient

_____ _____

Patient's Printed Name | Date

_____ _____

Office Staff | Date