Lifeline Medical Associates
Transforming Women's Healthcare
www.LMA-LLC.com

Women's Medical Connection
2080 Highway 35 Suite 1
Holmdel, NJ 07733

Rahab M. Khalil, MD

Office Policy

I understand that it is my responsibility to know my insurance policy with regard to physician participation, required referrals and covered services by my insurance company.

I understand that the Women's Medical Connection /Lifeline Medical Associates will bill my insurance carrier directly. Should I receive any payments directly from the carrier for services provided by the Women's Medical Connection, I agree to immediately forward such payments to the practice.

I agree to pay any copays and/or deductibles and co-insurance responsibility as per my insurance plan and that if I receive a bill from your office , I am required to pay it within a thirty (30) day period.

I hereby authorize the Women's Medical Connection to furnish information concerning my illness and treatment to my insurance company, or other treating physician. I also hereby assign the Women's Medical Connection payments for medical services rendered to myself. I understand that I am responsible for any amount not covered by my insurance.

No Show Policy: There will a $25 charge assessed to my account if I fail to cancel my scheduled appointment. (Cancellations must be made 24 hours prior to your scheduled appointment).

_____ Date: _____

Patient Signature/Responsible Party

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CONSENT OF USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date**_____

Due to HIPPA Rules and Regulations, we need your permission to discuss any personal information about you with anyone other than yourself. Please read the following and initial the line that applies to you.

____**I do not want my PHI (Personal Health Information) discussed with anyone other than myself.**

____**I give the Women's Medical Connection permission to discuss my medical information, insurance information, and any other PHI with the following individuals:**

_____ _____

Print Name and Relationship **Print Name and Relationship**

LIFELINE MEDICAL ASSOCIATES, LLC

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I _____, have received a copy of Lifeline Medical Associates, LLC's Notice of Privacy Practices

X _____ 10 _____

Signature of Patient Date

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding

the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Used and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose you health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of you health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.