

*Auburn Urogynecology and Women's Health*  
*James S. Dunn, Jr. M.D.*

**Privacy Practices, Authorizations, and Acknowledgement**

These authorizations, acknowledgements, and waivers cover all services rendered to the below named patient for today's services and all future dates of service. You may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any events that occurred before you notified us of your decision to revoke.

<b>Initial</b>	
Initial	<b>Acknowledgement of Receipt of Notice of Privacy Practice:</b> I am aware of the Notice of Privacy Practices of the patient outlined below. I understand that I may have a written copy to take with me upon my request.
Initial	<b>Authorization to Treat and Bill:</b> I give my consent for the patient outlined below to be treated by Auburn Urogynecology and Women's Health, James S. Dunn, Jr. MD, Inc (the company). I hereby assign to the company any insurance or other third-party benefits available for health care services provided to me. I hereby acknowledge that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I also authorize the release of any medical or demographic information necessary to process all claims.
Initial	<b>Waiver for Non-Covered Services:</b> It is my understanding that my insurance company may deem all or part of my visit as non-covered services. I will be responsible for payment for any and all serviced denies as non-covered. If your account is sent to collections, I am responsible for payment of any applicable fees needed to settle account.
Initial	<b>Medication History Authority:</b> I consent to the use of Rx Hub, which will gather my medication insurance eligibility information and history and download into my medical record.
Initial	<b>Communication Authorization:</b> <input type="checkbox"/> I consent to receive written communication to my address on file. <input type="checkbox"/> I consent to receive call/text/email automated reminders. <input type="checkbox"/> You may leave a message with detailed info on my preferred method of contact.
Initial	<b>Release of Information:</b> I consent to the release of my medical information and appointment scheduling to the following people.  Name: _____ Relationship: _____  Name: _____ Relationship: _____  Name: _____ Relationship: _____

By signing this form, I am only acknowledging that I have read and understand the above policies.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

If not signed by patient, please indicate relationship: \_\_\_\_\_