EXPLANATION OF OFFICE POLICY

FULL PAYMENT IS DUE AT TIME OF SERVICE	
Our office gladly accepts cash, checks, and all major credit cards.	
FOR PATIENTS WITH INSURANCE	
______ Initials	As a courtesy to our patients with insurance, we file your medical claims for services rendered. You are responsible for paying any deductible and copayment at the time of service. Our office staff makes every effort to be as accurate as possible when collecting these amounts; however, your insurance plan may not cover as much as we estimate. Any amount not paid by insurance is your responsibility. Once we receive payment from the insurance company, you will be required to pay the balance due upon receipt of your statement. The balance due for services provided is the patient's responsibility, even if the insurance company pays nothing. If you have overpaid your portion, you will receive a refund.
DELINQUENT ACCOUNTS	
______ Initials	We reserve and will exercise the right to report any account 90 days past due to a Collections Agency. All expenses incurred as a result will be the patient's responsibility, as permitted by law. Unpaid balances are subject to $35.00 late fee, $36.00 collection agency fee, court fees and interest rate of 20% on any unpaid balances over 30 days.
______ Initials	There is a $50.00 fee for all checks returned due as unpayable.
CANCELLATIONS & MISSED APPOINTMENTS	
______ Initials	Appointments are valuable blocks of time and when an appointment is broken or cancelled with short notice, we are often prevented from filling that time and helping other patients. Please give at least 24 HOURS NOTICE when you will not be able to make your scheduled appointment. Additionally, if you are more than 15 minutes late for an appointment, you may have to be rescheduled.
______ Initials	There is a $25.00 fee for all failed, rescheduled, and broken office appointments of 24 hours or less.
______ Initials	There is a $100.00 fee for surgeries that are not cancelled or rescheduled within 36 hours of the scheduled date.
PAPERWORK	
______ Initials	There will be a $25.00 charge for FMLA, disability, Prior Authorizations, and any other paperwork that needs to be completed by our office. Please allow 7-10 business days for completion.
______ Initials	Our office does not write work excuse letters without a medical reason to support the documentation. We do not write work letters for job reassignment recommendations, job limitations, or job specifications unless otherwise determined by Dr. Aguayo. We will approve "Appointment Day" excuses for the time seen in our office for work or school purposes.
MISCELLANEOUS POLICIES	
______ Initials	Due to cross coverage with other providers, you may see another provider if services are needed at a time when Dr. Aguayo is unavailable.
______ Initials	If you call to leave a message with your doctor or nurse, please allow up to 48 hours for a return call. Your call will be returned in a timely manner by our staff after appropriate discussion with the provider.
______ Initials	Prescriptions requested late Friday afternoon or over the weekend through the answering service, will not be filled until the next business day.
ALL PATIENTS PLEASE SIGN	
By signing below, I certify that I have read, understand, and agree to this office policy.	
Patient Signature____ Today's Date___________________	

Authorization to Contact Patient by Phone

You agree, in order for us to service your account or to collect monies you may owe, Edith Aguayo, MD PC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing services, as applicable. Further, I hereby authorize and give my consent to All Women's OB/GYN to leave messages on my voicemail system for the following:

______ Appointment Reminders ______Prescription Refills ______Medical Information ______ Test Results

I have read the disclosure and agree that Edith Aguayo, MD PC, its employees, and/or agents may contact me as described above.

Responsible Party Signature____Today's Date_____________________

Consent for Use and Disclosure of Health Information

1. This is to inform you that All Women's OB/GYN may use and disclose your health information that identifies you, and that consists of your past, present, or future physical or mental health or condition, the provision of your health care; and the past, present, or future payment for the provision of your healthcare (this health information is referred to herein as "Protected Health Information").
2. The use and disclosure of your Protected Health Information will be to carry out treatment, payment, and healthcare operations of All Women's OB/GYN.
3. For a more complete description of how All Women's OB/GYN may use and disclose your Protected Health Information, please refer to the available Notice of Privacy Practices. The terms of the Notice of Privacy Practices may change from time to time; therefore, to obtain a revised Notice of Privacy Practices, please contact the Privacy Officer.
4. You have the right to request that All Women's OB/GYN be restricted from using and disclosing your Protected Heath Information in carrying out Treatment, Payment or Health Care Operations; however, All Women's OB/GYN is not required to agree to your requested restrictions. If All Women's OB/GYN does agree to your requested restrictions, then it will comply with your request.
5. You have the right to revoke this Consent. This revocation must be made in writing to All Women's OB/GYN. This revocation will be valid except to the extent that All Women's OB/GYN has taken action in reliance on this Consent.

By signing this document, you acknowledge that you have read and understand this Consent. Further, you hereby consent and authorize All Women's OB/GYN to use or disclose your Protected Health Information in conjunction with All Women's OB/GYN Treatment, Payment, or Healthcare Operations in accordance with the terms of this Consent.

____ ____

Signature(Patient) Signature (Authorized Representative)

____ ____

Date of Birth Today's Date

I have received a copy of the Notice of Privacy Practices:_____________(Initials)

Further, I hereby authorize and give my consent to All Women's OB/GYN to communicate any of my Protected Health Information to the following persons:

Name	Relationship