New England OB-GYN Associates, Inc.
Patient Consent and Waiver Form

My signature authorizes New England OB/GYN Associates, Inc. (NEOGA) to release any medical or other information for the purpose of treatment, payment, or health care operations, among other purposes (such as disclosures required by law and under certain special circumstances), as follows:

1. **Treatment**. NEOGA may use your protected health information (PHI) to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for NEOGA including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. **Payment**. NEOGA may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health care operations**. NEOGA may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. **Privacy Policy**. I have reviewed NEOGA's Confidentiality/Privacy Policy.

5. **Patients Rights and Responsibilities**. I have reviewed NEOGA's Patient's Rights and Responsibilities statement.

May we share your protected health information with your spouse, significant other, or parent?

Please circle YES NO If answered yes:

_____ _____
Name of party to share information with Relationship to patient

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I authorize payments directly to NEOGA. I understand that I am financially responsible for any charges not covered or denied by my insurance company. Upon request NEOGA will provide the billing codes and estimated corresponding charges for the services I will be billed for and also provide insurance carrier contact information.

I, _____, understand that

- **NOT COVERED BY INSURANCE**:
  I understand that I am or will be responsible for all charges associated with today's visit should my insurance (if applicable) not cover charges.

  NO REFERRAL /AUTHORIZATION AT TIME OF VISIT:
  I understand that I am or will be responsible for all charges associated with today's visit if I do not provide/obtain a valid referral prior to services being rendered and still wish to be seen, I will be responsible for all charges if denied by your insurance.

- **NO INSURANCE:**
  I understand that payment is expected on the date of service for all charges.

- **CHANGES IN INSURANCE COVERAGE:**
  I understand that if insurance coverage has either changed or termed effective on this date of service, I am responsible for any charges that are not collectable due to timely filing, if NEOGA has been not provided with accurate billing information at the time services are rendered.

Note:

I understand that during an Annual Wellness Exam, the focus is routine health maintenance. Health Maintenance includes recommendations for screening tests, risk factor reductions, and healthy lifestyle. If I have chronic health problems or acute health issues discussed and managed during my wellness exam, the two services may be billed as an age appropriate preventative medicine exam and as a problem focused visit.

With the implementation of the Affordable Care Act, there have been changes to the coverage of screening lab tests with some insurance plans. If a lab is done for specific diagnosis rather than a screening, it will most likely not be covered under my Wellness/Preventative coverage benefits meaning I may owe part or the entire allowed amount. This does not mean that the services were denied by my insurance company, rather they were allowed by being applied to my deductible or co-insurance according to my benefits.

_____ _____
Print Name DOB

_____ _____
Signature Date