Decatur Morgan OB-GYN
Decatur Morgan Hospital

Financial Policy
Acknowledgment of Notice and Release of Information

Welcome to Decatur Morgan OB-GYN. We are committed to giving you the best care possible. We would like to take this opportunity to inform you of our office financial policies.

We will bill insurance claims as a courtesy to our patients, provided we have your current information and any necessary referrals. Should your insurance require a referral and we have not received it prior to your appointment, you will be responsible for payment in full at the time of service. We accept payment from insurance companies, but require that you pay your portion, including co-pays, deductibles or coinsurance at the time of service.

Each insurance plan is different and has its own policies on what is and is not a covered benefit. While we do make efforts to verify coverage under your plan, it is ultimately your responsibility to know what is covered and which benefits fall under your plan. It is also your responsibility to verify that our providers are in your network.

The laboratory company is a separate entity and will bill you or your insurance company for labs that are performed. If you have any questions regarding your lab bill, please contact that laboratory or your insurance company.

As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. We ask that you notify us 24 hours in advance to cancel and/or reschedule your appointment. We reserve the right to dismiss patients from the practice if they have a pattern of missing appointments without notification.

It is your responsibility to notify our office if there is a change of name, insurance coverage, residence and/or phone number.

I have read the above Financial Policy. I understand and agree to these terms. _____
(Please initial)

Acknowledgement of Notice

I acknowledge the receipt of the Notice of Privacy Practices for Decatur Morgan OB-GYN. _____
(Please initial)

Release of Information

I authorize my Personal Health Information (PHI) to be disclosed as specified below:

Primary Number: _____ Acceptable to leave a message on this number: YES NO

Secondary Number: _____ Acceptable to leave a message on this number: YES NO

To the following family member(s) or other person(s):

_____ / _____ / _____
Name Relationship Phone Number

_____ / _____ / _____
Name Relationship Phone Number

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can revoke or change this information at any time by completing a new form. This authorization remains in effect until I change or revoke it. I understand that PHI shared with the above individual(s) may be subject to re-disclosure by those individual(s).

_____ _____
Patient Name (Please Print) Date of Birth

_____ _____
Signature of Patient / Guardian Today's Date

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
Medical Records Release/Request Form

Patient Name: _____
(Last, First, Middle) (Previous Name)

Address: _____

Date of Birth: _____ Telephone #: _____ Social Security Number: _____

Reason for Record Request: _____

Release Records **FROM** Decatur Morgan OB-GYN **TO:**		Release Records **TO** Decatur Morgan OB-GYN **FROM:**
_____ (Name)		_____ (Name)
_____ (Address)	**OR**	_____ (Address)
_____ (City, State, Zip)		_____ (City, State, Zip)
_____ (Phone Number) (Fax Number)		_____ (Phone Number) (Fax Number)

I hereby authorize the release of photocopies of the following medical records in the possession or control of the above named facility, its employees and/or agents. For the purposes hereof, *"medical records"* shall include all confidential HIV-related information, confidential communicable disease-related information, confidential alcohol or drug abuse related information, confidential genetic testing, and mental health diagnosis/treatment information.

Information to be Released:

__ All Medical Records __ Obstetrical Records Only __ GYN Records Only __ Radiology Reports

__ Laboratory Reports __ Operative Reports __ Pathology Reports __ Past 2 Years

__ Other Records (specify) _____

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Decatur Morgan OB-GYN based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

This authorization expires within six (6) months from the date signed. If you wish to have the authorization expire before six (6) months, please indicate the date of expiration: _____.

It is further understood that there may be a fee, payable by the patient for releasing these records.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed Name if signed on behalf of patient Relationship (parent or legal representative)

A copy of this release shall be as binding as the original.

1215 7th Street SE, Suite 240, Decatur, AL 35601

Phone: **(256) 973-5216** ***Fax:*** **(256) 973-3177**

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Patient Information

Name: _____ Social Security Number: _____ Birthdate: _____

Address: _____ City, State, Zip: _____

Primary Phone: _____ Secondary Phone: _____ Marital Status: S M D W Separated

E-Mail Address: _____ Race: _____ Employer: _____ Occupation: _____

Name and Phone # of Family Doctor: _____

Preferred Pharmacy (City, Zip & Phone): _____

Who may we thank for referring you to our office? _____

Spouse (if married) or Parent (if minor)

Name: _____ Social Security Number: _____ Birthdate: _____

Address: _____ City, State, Zip: _____

Phone: _____ Relationship: _____ Employer: _____

Insurance Information

Primary Insurance: _____

ID#: _____ Group #: _____

Policy Holder Name: _____

Policy Holder DOB and Sex: _____

Secondary Insurance: _____

ID#: _____ Group #: _____

Policy Holder Name: _____

Policy Holder DOB and Sex: _____

Do you currently have and Advanced Directive regarding your medical wishes: _____

Authorization, Assignment & Consent to Treat

The patient or authorized person agrees that the above information is correct and allows for the medical treatment as specified by physician or associate provider.

I hereby authorize Decatur Morgan OB-GYN to release any information requested, including information, to any insurance company, employer, third party payer, or third party administrator for purposes of processing my claims. I hereby assign Decatur Morgan OB-GYN ALL payments for medical services rendered to me or my dependents. As the responsible party, I agree that I am financially responsible for ANY unpaid amounts, and agree to pay service charges at the current rate, collection charges, bad check charges, and court costs, including any reasonable attorney fees.

If required, I understand that I am responsible for obtaining an insurance referral to be seen in this office. I understand I am responsible for any charges incurred due to denied benefits if a proper referral is not obtained.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date:_____