Patient Authorizations

Patient Name: _____ DOB: _____

Acknowledgement of Receipt of Notice of Privacy Practices
I hereby acknowledge reviewing the Notice of Privacy Practices brochure from SW FLORIDA OBGYN, LLC. I understand that: 1) the Notice may be amended at any time, 2) notice of such amendment may be posted in the front office and 3) I may obtain an updated brochure from the office during regular business hours.
Initials _____

Health Information Consent
I understand that my medical records may contain information about but not limited to: alcohol/ drug treatment, mental health or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my protected health information (PHI) in accordance with the Notice of Privacy Practices. I also understand that records may be sent via telefax and I relieve SW FLORIDA OBGYN, LLC and their staff from any liability for miscommunication by telefax.
Initial _____

Please be aware that this office will not disclose your protected health information (PHI) to anyone without your consent. Please indicate below those person(s) which you designate to receive this information on your behalf.
Name _____ Name _____

Name _____ Name _____
Initials _____

Assignment of Insurance Benefits
I hereby authorize direct payment of surgical/medical benefits to SW FLORIDA OBGYN, LLC (FWC) for services rendered by physicians or supervised medical staff. I understand I am financially responsible for any balance not covered by my insurance company. I authorize release of any medical information necessary to process my medical claims.
Initials _____

Financial Policy Statement
I have reviewed a copy of the Financial Policy Statement and agree with all terms listed.
Initials _____

CDC Date Collection Program (Use CDC sheet for selections)

Please identify your Race from the previous CDC list: _____

Please identify your Ethnicity form the previous CD list: _____

_____ _____
Signature **Date**