Receipt of Notice of Privacy Practices
Written Acknowledgment Form

I have been presented with a copy of Perennial Women's Wellness Notice of Privacy Policies, detailing how my information may be used and have disclosed as permitted under federal and state law. I understand the contents of the notice and request the following restriction(s) concerning the use of my personal information.

Name (please print): _____
Patient Signature/Legal Representative: _____
Relationship: _____ Date: _____

Designation of Personal Representative

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this for you are informing us of your wish to designate the name(s) of the person(s) as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

Designation Section
The person(s) is to be afforded all of the privileges that would be afforded to me with respect to my health information, including test and lab results, appointment information and financial information.

I, _____ (print name) hereby nominate the following person(s) to act as my personal representative with respect to decisions involving the use and disclosure of health information that pertains to me.

1.) _____
2.) _____

- ☐ Patient declines personal representative
- ☐ I consent to text messages, voicemails and emails for appointment reminders, lab results, and payment owed.
- ☐ I authorize the release of my medical record or any information contained in this record to primary care and referring physicians.

Signature: _____ Date: _____

Revocation Section:

I hereby revoke this designation of a personal representative.

Signature: _____ Date: _____

Office Policy and Procedures

Prescriptions: Please discuss with your provider during your scheduled visit. If you call regarding refills, please allow up to 48 hours and check with your pharmacy. We will call you with any questions or concerns. There will be a $10 charge for calling in NEW prescriptions without an appointment. You will be responsible for payment. There will be no charge for refills of medications currently prescribed to you by our office. Please be aware that refills will not be called in after hours. You will need to call the office during regular business hours to request refills.

Phone Messages: Please allow 24 hours for a return call. Messages may not be returned until the end of the day, after the last patient in the office is seen. Multiple phone calls regarding the same issue will only delay the process.

Results of Tests: We will call you with your lab results within 2 weeks. There is no need to call the office regarding results. This will only delay the process. As of January 1, 2022 we will no longer send letters regarding normal pap results. Lab results will be available on the patient portal, **Patient Fusion.**

Referrals: Please allow 4-5 business days for scheduling referral appointments and outpatient procedures. Urgent appointments will be scheduled as soon as possible. This amount of time is required to verify insurance and meet prior authorization requirements. If you need to change the appointment you may contact the referral office to reschedule.

Medical Records: You are entitled to one free copy of your medical records. Once a valid release is on file, please allow 30 days for the request to be processed. After the free copy, a charge of $1 per page applies.

Documentation Requests: There is a $10 fee for the majority of documentation services. Such services include FMLA forms, life insurance forms, disability forms, homebound papers, and letters written on behalf of the patient. Payment must be made before documentation will be completed. This fee will be waived for surgery patients.

Late Arrivals: Please call us as soon as you know you may be late. Depending on how late you arrive, you may be worked in or asked to reschedule your appointment.

Social Media Policy: Please contact our office via phone, not social media. Our office staff will not respond to you via social media. If it is after hours, please contact the office for directions on how to reach your provider, if it is a medical emergency, you should go to the nearest emergency room or call 911. *This practice does not permit audio or video recording of any type.*

Weight Loss and Aesthetic Services: *Please note that we do not bill insurance for the medical weight loss program or aesthetic services. You are responsible for charges incurred for such services.*

I have read and understand the above policies. Any questions I have were answered by the office staff at Perennial Women's Wellness. I understand that I am responsible for any fees that I may accrue that are not billable to my insurance company.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Witness: _____

Financial Policy

Appointment Cancellation and No Shows: Please give at least 24-hours notice of cancellation. This will allow time for us to offer that appointment to another patient. A fee of **$25** may be charged for a no show.

Billing: Please remember that your insurance policy is a contract between you and the insurance company. You may need to contact your insurance company to resolve payment disputes. Payment for services is your responsibility and will be expected from you if insurance denies payment for services.

Patient Balances: Co-payments are required the day of services. If you have an outstanding balance, you will be expected to pay your balance plus your co-pay or current visit charges prior to seeing the provider. Other payment arrangements may be made prior to the visit in some circumstances. We accept credit/debit cards, however we prefer cash or check if possible. There will be a $25 fee for returned checks.

Credit Card Transactions: Effective January 1, 2019, there will be a service charge for all credit card transactions that equals the sales of transaction cost to the office. Currently this is 2.25% of the transaction amount.

I understand that I have come to Perennial Women's Wellness to receive medical treatment for which I will be first and foremost responsible for the services rendered during my visit. I understand I may receive emails and/or texts to the number and email I have provided regarding my balance when payment is due. I understand and agree that payment is expected when services are rendered. _____ **Initial**

It is the responsibility of the patient to provide our practice with current/active insurance information. If you cannot provide your current/active insurance information, you will be responsible for the entire balance. Please check with your insurance to see if your provider is in-network. If our providers are not listed in your plan, you may be responsible for the entire bill. Your insurance company and plan benefits ultimately determine the amount paid. All charges you incur are your responsibility regardless of insurance coverage. _____ **Initial**

I further agree that this office may bill my insurance company and I agree to assign any and all payments of benefits to Perennial Women's Wellness. In the event that Perennial Women's Wellness does not participate with my health/medical insurance company, if I have any remaining balance after any and all insurance payments, or if I have a third party payment source, I understand and agree that I will solely be responsible for the balance of my account.

I also acknowledge that interest may be charged on all accounts which are sixty (60) days or more past due at a rate of 1.5% per month or 18% per annum), I understand that interest charges may be added to any account that I have that is sixty (60) days or more past due and I hereby agree to pay any and all such charges.

If my account is not paid in full or payment arrangements are not made within sixty (60) days and my account is placed in the hands of an attorney or collection agency for the purpose of collection, or a suit is instituted to collect the same of any portion thereof, I agree to reimburse Perennial Women's Wellness the collection fees of any collection agency,which shall be based on a percentage at a maximum rate of 33.3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fee incurred by the collection agency This contract shall cover all medical treatment and services until revoked by either party in writing.

Weight Loss and Aesthetic Services: *Please note that we do not bill insurance for the medical weight loss program or aesthetic services. You are responsible for charges incurred for such services.*

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____