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NON COVERED SERVICES

I, _____, understand that if a service or procedure performed by my physician is not covered under my medical plan I will be financially responsible. My physician may order lab work or radiology from an outside laboratory and I understand that the physician is in no way responsible for the associated fees of any non-covered services.

I am here today for ___ Annual Well Woman Visit
___ Problem Oriented Visit
___ Pregnancy Oriented Visit
___ Procedure (in office)

My current medications include:

It is your responsibility to notify us in writing of any change to your insurance coverage, address or phone numbers. Our business office is open during regular office hours, and we welcome any questions you have regarding our financial policy.

Signature of Patient: _____ Date: _____

Witness: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, agree to allow Walnut Hill Ob/Gyn to disclose my Private Health Information (including date/time of appointments) to:

_____ Tel (____)_____

Name of Individual and Relationship

_____ Tel (____)_____

Name of Individual and Relationship

___ Myself only, no other family member

I have received a copy of Walnut Hill Obstetrics and Gynecology Associates' Notice of Privacy Practices.

Signature: _____ Date: _____

WE ATTEMPTED TO OBTAIN WRITTEN ACNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACNOWLEDEMENT COULD NOT BE OBTAINED BECAUSE:

___ Individual refused to sign

___ Communication barriers prohibited obtaining the acknowledgment