NON-COVERED SERVICES

I, _____, understand that if a service or procedure preformed 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.

Signature of Patient: _____ Date: _____

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.

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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, _____, agree to allow Walnut Hill Ob/Gyn to call my ☐ Cell
☐ Home
☐ Work

If you are unable to reach me you can ☐ Leave a detailed message
☐ Leave a message for me to return your call only.

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

WE ATTEMPTED TO OBTAIN WRITTEN ACNOWLEDGE MENT OF RECEPIT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACNOWLEDEMENT COULD NOT BE OBTAINED BECAUSE:
___ Individual refused to sign
___ Communication barriers prohibited obtaining the acknowledgment