NON-COVERED SERVICES / NO-SHOW FEES

I,_____, understand that if a service or procedure preformed by my physician isnot 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 further understand that if I do not cancel or reschedule my appointment with at least 24 hours' advance notice and do not show for my appointment, I will be charged a $50 no-show fee per missed appointment.

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 ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

____Individual refused to sign
____Communication barriers prohibited obtaining the acknowledgement

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Consent to treat:

I consent to and authorize the physicians, nurses, and other healthcare providers at Walnut Hill Obstetrics andGynecology to preform appropriate healthcare examinations, treatment and diagnostic testing or medication administration as deemed medically necessary by their professional judgement. I know that there is some riskwith all medical treatments and procedures, and I understand that no one can guarantee how procedures and treatments will work.

Patient Signature:_____ Date: _____