Consent & HIPAA Acknowledgement Form

Name: _____ **Date of Birth:** _____

Consent for Treatment: I hereby give consent for the physicians and staff of OBGYN Associates of Akron, Inc., to examine me and to render medical care and treatment to the above-named patient. I further authorize OBGYN Associates of Akron, Inc., physicians, and staff to perform such diagnostic and therapeutic procedures and to administer such medications as may be necessary and appropriate for diagnosis and treatment.

Authorization: I authorize OBGYN Associates of Akron, Inc., to release to my insurance company, state agency, federal agency, Medicare, Medicaid services, or other likewise agents any information that is required to process my insurance claim and/or to determine benefits payable for related services. I also authorize OBGYN Associates of Akron, Inc., to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing medical records may increase risk of accidental disclosure of my medical records. I grant permission to OBGYN Associates of Akron, Inc., to release all or part of my medical records to any consulting entity that may be involved in my care including, but not limited to, consulting physicians, physicians I am referred to, testing facilities, and outpatient facilities. I also authorize payment of my medical benefits be made directly to OBGYN Associates of Akron, Inc., on my behalf whether I am covered by Medicare, Medicaid, or Medicaid HMO, commercial insurance, or any other medical benefit company or payor.

Guarantee of Payment: I understand that I am financially responsible for the deductible amounts, co-payments, co-insurance amounts, non-covered services and charges, and any and all balances not covered by contractual write-off between OBGYN Associates of Akron, Inc., and my third-party payor. My carrier's failure to pay does not release me from this responsibility. I also agree that should my account be turned over to collections, that I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

By signing below you acknowledge that you have read and understood all of the above information, which in summary includes (but is not limited to) consent for treatment, authorization to release medical information for claims processing, and authorization for our office to receive benefits on your behalf. This signed document will remain in effect unless and until you revoke it in writing.

Patient Signature: _____ **Date Signed:** _____

Patient Rights and Responsibilities: I acknowledge that I have seen the Patient Rights and Responsibilities notice posted in the patient lobby and that I understand my patient rights and responsibilities.
Initials: _____ Date: _____

Additional Consent: I hereby authorize OBGYN Associates of Akron, Inc., to leave a detailed message on my answering machine and/or voice mail regarding any test results:
YES _____ NO _____ Initials: _____ Date: _____ Phone # (_____) _____ - _____

HIPAA: I, the undersigned, attest to the fact that I have been informed, in writing, of the privacy practices of OBGYN Associates of Akron, Inc., that are in accordance to all federal HIPAA guidelines.

Patient Signature: _____ **Date Signed:** _____

HIPAA Notification: Unless you opt out in writing, HIPAA allows the disclosure of a limited amount of your health information to family members, friends, or others you have identified below when you are unavailable, incapacitated or in an emergent condition, and the practice thinks it would be in your best interest to do so. Please select one of the options below.

My health information may be released to: _____

Signature/Date: _____ **Witness:** _____

OR

I am electing to opt-out so that no health information is released to family, friends, or others.

Signature/Date: _____ **Witness:** _____