Genesis Gynecology, P.A.
176 Fairway Drive
Kerrville, Texas 78028
(830) 792-0805 Fax (830) 792-0833

FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

If you are new to our office, thank you for choosing this office for your medical needs. If you are an established patient of Genesis Gynecology our policy may be new to you. It is our intent to treat our patients in a courteous and professional manner with regard to financial matters. Our goal is to obtain a desirable financial arrangement for our services. However, our office is a business which provides services to patients and sometimes provides supplies that we purchase from other vendors. Our physicians are here to provide medical advice, services and treat patients, not to discuss financial arrangements. All financial arrangements are made through our business office.

Our policy is to be paid at the time services are rendered. If you do not have insurance to help you with your medical cost, or if you have deductibles or co-insurance your insurance holds you responsible for, we ask for payment of such liabilities prior to or directly after services are provided. If Dr. Truelock suggests a procedure or surgery, then it is the patient's responsibility to discuss and meet their financial obligations with the business office manager. If you are unable to pay at the initial time set forth, we are willing to discuss options that are available and come to a mutual agreement. We are not able to provide services to patients free of charge; however, we will be happy to recommend you to other facilities and services in the community who can assist you. We are here to discuss these options with you if you so desire.

If you are an established patient of Genesis Gynecology, your credit history with this office will be reviewed upon each new procedure or surgery scheduled.

If you have questions regarding our policy, please feel free to speak with our business office manager prior to your services.

Basic policy: Payment for service is due in full at the time service is provided in our office.

For patients with insurance: We bill most insurance carriers and secondary insurance companies for you if proper paperwork is provided to us. Co-payments and deductibles are due at the time of service.

Medicare patients: We will bill Medicare for you. We will also bill secondary insurance carriers for you. All co-payments and deductibles are due and payable at the time of service provided.

Surgery Fees: All co-pays and deductibles, payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.

Noncovered services: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Yearly Health Checks: Periodic preventive health checks may or may not be covered under your health insurance policy.

Missed appointments: In fairness to other patients and to the doctors, we require at least 48 hours' notice to cancel appointments. You may be charged a fee for missed appointments and/or dismissed from the practice for multiple missed appointments if notice is not given.

Medicare Patients: Signature on file: I request payment of authorized Medicare benefits be made either to me or on my behalf to Genesis Gynecology, P.A. for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (print): _____ Medicare #: _____

Patient's Signature: _____Date:_____

Assignment of Insurance Benefits: Patients with insurance please read and sign below.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Genesis Gynecology, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature:_____ Date:_____

I have read, understood, and agreed to the above financial policy for payment of professional fees. The patient is ultimately responsible for all professional fees.

Signature: _____ Date:_____

Genesis Gynecology, PA

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information (PHI). Please read it carefully before signing.

Genesis Gynecology, P.A. will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Genesis Gynecology, P.A. may use or disclose protected health information for the purpose(s) of diagnosing or providing treatment, obtaining payment for services rendered or to conduct health care operations.

By signing this authorization you agree that Genesis Gynecology, P.A. or its Business Associates may disclose your personal health care information by fax, telephone, mail or e-mail to other physicians, healthcare facilities, or insurance companies.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Genesis Gynecology, P.A.'s HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Genesis Gynecology, P.A. has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Genesis Gynecology, P.A. or by sending a written request with return address to 176 Fairway Drive, Kerrville, Texas, 78028.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Genesis Gynecology, P.A. for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Genesis Gynecology, P.A. has taken action in reliance on it. A revocation is effective upon receipt by Genesis Gynecology, P.A. of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization; (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA; (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Genesis Gynecology, P.A.; or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Acknowledged and agreed to by:

Patient Signature: _____ Date: _____

I have reviewed the completed information on the Patient Registration Form and the information is accurate and true. I also have read and understand the Financial Policy statement. I know that the HIPAA notice of privacy practices is posted in the office of Genesis Gynecology, P.A., and that I may request a copy.

I hereby authorize Genesis Gynecology, P.A. and its physicians to furnish information concerning illnesses and treatments of the above named patient to any third party payor with whom the patient is under contract. I hereby authorize payment of benefits directly to Genesis Gynecology, P.A. otherwise payable to me for medical and/or surgical services rendered.

I hereby permit the doctor or his assistant to take photographs or other digital images of the above named patient. I understand that these images are for legal documentation or presentation at professional meetings and discussions, and I give permission to use them as such.

The following people may have access to my chart _____

_____

Signature:_____

Date:_____

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