11970 N. Central Expwy Suite 300
Dallas TX 75243
(972)380-1099
www.healthwellnessmd.com

Consent for Treatment

You will be required to provide the receptionist your insurance card and current drivers' license AT EACH VISIT. If you do not have a valid insurance card, you have the choice of rescheduling your visit or paying in full at the time of your visit (reimbursement will be provided if insurance payment is received after filing).

Insurance issues, requirements and coverage are ever changing, and we are making every effort to eliminate payment denials. Please keep in mind, if an annual visit is scheduled and a problem is discovered during your exam or if you present a problem/complaint during your annual visit, by contract, both services must be appropriately documented in your medical records and billed for. Depending on the coverage you have, you may be responsible for a portion of the billed amount at the time of service. We cannot change the coding (fraud) to ensure that your insurance company will pay for a non-covered service***. Please note we do not accept Medicare or Medicaid***

General Consent for Treatment:
"Knowing that I am seeking preventative care and/or suffering from a condition requiring diagnostic, medical or surgical treatment do voluntarily consent to such procedures, care and to such medical, surgical or other services under the general and specific instruction of Dr. Maryann Prewitt at Health Care for Women, PA her assistants, or her designee as is necessary in her judgment. I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examination– Texas Medical Association.

I agree that should I not receive the results of tests within 2 weeks upon their completion, it is my obligation to call the office and inform them of this. I also understand that if Dr. Prewitt orders diagnostic studies and I do not complete them in a timely manner, Dr. Prewitt and our office is not liable for any delayed diagnosis. _____ **(Patient's Initials)**

HIPAA REQUIRES THIS MUST BE COMPLETED

Last Name: _____ First Name: _____ Middle Int: ____

Address: _____

City: _____ State: _____ Zip Code: _____

Evening Phone #: _____ Day Time Phone: _____ Is there an Ext?: _____

Cell Phone: _____ Date of Birth: _____ SS#: _____

Marital Status: _____ Driver's License #: _____ State:_____

Insurance:_____ Insured's Name:_____

Insurance ID#:_____ Insured's DOB: _____ Insured's SS #:_____

Referred by: _____ Send updated records to referring phys? Yes or NO

_____ DATE: _____ TIME: _____AM/ PM
Signature of responsible party

If signed by a legal representative, relationship to patient: _____

(SIGNATURE OF WITNESS/EMPLOYEE): _____

I UNDERSTAND THAT IF I DO NOT HAVE A COPY OF THE FINANCIAL POLICY OF HEALTH CARE FOR WOMEN, PA, I WILL ASK ONE OF THE STAFF
FOR A COPY.
Some health plans require that we inform you *in advance* that they may deny payment for "services not covered" and for "services not deemed by the health plan to be reasonable and customary or medically necessary." Health Care for Women, PA renders only services that, in their professional judgment are needed to provide quality medical care for you. In order for us to collect from you for our services when payment is denied by your health plan, your health plan requires that you sign the following agreement. Agreement:
I have been notified by the physician that payment may be denied for "services not covered" or for "services not deemed by the

health plan to be reasonable and customary or medically necessary" or that have been specifically requested by me, the patient.
If payment is denied, I agree to be personally and fully responsible for payment.

Signature: _____ **Date:** _____

Our office is committed to providing you with the best possible care and helping you to receive your maximum allowable benefits under your health plan. In order to achieve these goals, we need your assistance.
REGARDING OFFICE VISITS, LAB WORK, SONOGRAMS & ANY TESTING: It is your responsibility to know if a referral is necessary for your visit.

If you miss your appointment or cancel your appointment without 24 hour notice, you will be charged a fee of $25 (Tue. through Fri.) and $50 (Saturday.)
It is your responsibility to check with your insurance if any tests we request (mammogram, bone density, sonograms, MRI, labs, etc) are covered or need referrals. Co-payments/co-insurance is due at time of visit. Also, be advised that there is a fee for phone appointments and your insurance will be billed for the call. If the service is not a covered benefit or if your plan tells us you are not covered, payment in full **is due for all services rendered.** If your insurance company subsequently makes a payment, any overpayment will be refunded to you. These laboratories will submit charges to your insurance company. In the event your insurance company does not pay you will receive a statement from the lab. Please contact the number on their statements regarding questions about your lab charges.

REGARDING YOUR HEALTH PLAN
Your insurance is a contract *between you, your employer and the insurance company.* While we may have an agreement with many of the health plans to provide services, you must resolve any questions regarding coverage with the insurance company. Not all services are a covered benefit in all contracts: some health plans select certain services that they will not cover (i.e. contraceptives, elective surgery, cholesterol screenings, etc.). We will confirm eligibility with your primary insurance company. All patients will be informed of benefits prior to your elective surgery. All patients are required to pay a deposit for this care dependent on your benefits (i.e. deductible and co-payment etc.) When we confirm your eligibility, your insurance company will say this is a quote of benefits, and not a guarantee of payment. Therefore, we are only giving you an ESTIMATE of benefits. We will file with your insurance for all surgical procedures.

I am assigning benefits to the provider. In the event of non-payment by my insurance carrier within 45 days, I will be responsible for full payment. I will then have to seek reimbursement from my insurance carrier. Upon receipt of statements, if payment is not received within 14 days, collection process will be initiated. I also understand that I am responsible to provide the office with any insurance changes 24 hours prior to my appointment. _____ (Patient's initials)

I HAVE READ THIS DOCUMENT, UNDERSTAND AND AGREE TO THESE OFFICE POLICIES & ASSIGNMENT OF BENEFITS.
I HAVE RECEIVED, READ AND UNDERSTAND THE CURRENT FINANCIAL POLICY & GENERAL CONSENT.
I UNDERSTAND THAT SHOULD I REQUEST MY RECORDS BE SENT TO ANOTHER GYNECOLOGIST I AM INACTIVATING MYSELF AS A PATIENT.
I HAVE RECEIVED, READ AND UNDERSTAND THE SUMMARY OF THE NOTICE OF PRIVACY PRACTICES.
I UNDERSTAND MY FINANCIAL OBLIGATIONS AND AM AWARE OF LATE CHARGES IF MY FULL BALANCE IS NOT PAID IN 30 DAYS.

By signing below, I acknowledge that I have read this information and understand it completely.

Signature: _____Date: _____

Patient Privacy Directive

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please provide us with the phone number(s) that we can text or leave an automated message regarding appointments:
_____

Please provide us with the phone number(s) that we or an automated service may leave messages regarding treatments and/or test results: _____

Please provide us with the name(s) and phone number(s) that we may talk to regarding your appointments, treatments, billing and/or

test results: _____

Please provide an email address that we may communicate health information and/or skinFIT Med Spa specials:

_____

Please provide us with a cell phone number that we may text health information to: _____

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Please provide us with the name and number of your emergency contact: _____

You must inform us IN WRITING of any changes in your directives.

I acknowledge that everything is accurate and have seen or been offered a copy of the "Notice of Privacy Practices".

_____

Signature Patient | Printed Name | Date

_____

Relationship if Patient is Representative | Physician Office Representative