Northside
WOMEN'S HEALTH
Dr. Heidi Arbona
Dr. Tammy Chan

660 Cooper Road
Suite 700
Westerville, OH 43081
614-865-7600
Fax 614-392-2546

Northside Women's Health
Patient Consent and Authorization

1. **Consent to Medical Care and Treatment**

   While at Northside Women's Health, I consent to all medical and surgical care, examination, tests determined to be necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. If I refuse treatment that is suggested for me, or if I leave against medical advice, I will not hold Northside Women's Health or an individual responsible for any consequences.

2. **Release of Information**

   Our Notice of Privacy Practices provided information about how we may use and disclose protected health information about you. This notice contains a Your Rights section describing your rights under the law. You have the right to review our notice before signing this consent and authorization. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

3. **Acknowledgement of Notice of Privacy Practices**

   I acknowledge that I have received or been offered a copy of Northside Women's Health's Notice of Privacy Practices and have had a chance to object to the use of or disclosure of my information.

4. **Financial Responsibility**

   I understand and agree that I am financially responsible for payment of all charges incurred, which are not paid by insurance benefits. I agree to pay Northside Women's Health for charges incurred, including incidentals. In understand that services rendered to me may not be eligible for benefits under Medicare, Medicaid, or other insurances or payers. Services not eligible for benefits may include tests and procedures that are not covered, or those delivered by health care providers who did not participate with my insurance plan. If you are unable to keep an appointment, advanced 24 hour notification is required. Two missed appointments could cause termination of your medical care at our office.

5. **Personal Valuables**

   I understand that Northside Women's Health does not accept responsibility for any lost, stolen or damaged personal items.

6. **ALTERNATIVE MEANS OF COMMUNICATION**

   The HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means; such as sending correspondence to the individual's office.

I wish to be contacted in the following manner (circle all that apply):

Home Telephone ______________________________

OK to leave message with info?
Leave message with callback number?

Work Telephone ______________________________

OK to leave message with info?
Leave message with callback number?

Written Communication ______________________________

OK to mail to home address?
OK to mail to work address?

Other ______________________________

I have read and understand the above patient consent and authorization form. A copy may be given upon request.

____
Patient Name (please print) Date

____
Patient or Guardian Signature Date

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Northside Women's Health
Privacy Consent - For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy in respect to your health care information.

I hereby give my consent to Northside Women's Health, LLC and any employee working under the directions of the physician, to provide medical care for me, or to this patient for whom I am the legal guardian. This medical care may include services related to my health (or the identified person) and may include (but not limited to) preventative diagnostic, therapeutic rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent included contract and discussion with other health care professionals for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent related to the Privacy Notice: I have had the chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed by this practice is not required to agree to my restrictions. If it does agree to my restrictions n PHI, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time by the practice may refuse further services at that time. If I revoke this consent, the revocation does not take effect until the practice receives the notice.

Patient or Guardian ______________________________ Date ______________

Name Printed ______________________________ Relationship to Patient ______________

Consent for assignment to benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co payments, amounts applied to deductible and other amount that me be deemed my responsibility by payment sources, as required by my insurance plan and state regulation. I further understand that my contract with this insurance entity may or may no cover some services. It is my responsibility to obtain information from my health plan about services not covered. If I seek care outside of this contract, I am aware I may be responsible for all charges that are incurred.

Patient/Guardian ______________________________ Date ______________