All About Women Health Associates, Inc
Acknowledgement of Receipt of Notice, Authorization & Release

(If you do not wish to comply with the statements below, please place an X on that statement)

I understand that the provider must have all current insurance information prior to being seen for my appointment. I understand that the services may be covered by the payer but I will be responsible for the expenses incurred and that the provider will not submit any claims to a payer if the correct information is not provided at time of service.
I authorize the release of any information including the diagnosis and the records of any treatment rendered to me or my dependent to third party payers.
I authorize and request my insurance company to pay directly to All About Women Health Associates, Inc (AAWHA) any fees for services rendered.
I understand that my insurance carrier may pay less than the actual bill for services. Contractual adjustment with managed care contracts will be accepted, but I agree to be responsible for payment of all billable services rendered on my behalf or my dependents.
I understand that my insurance company may provide the insurance policyholder some or all of my health information during the billing process.
I authorize release of information to my Primary Care Physician or Specialty Physician, whom I am under the care of.
I authorize you to transmit my medical records electronically/fax when necessary. I absolve AAWHA and/or any professional providing services on behalf of AAWHA of any liability relating to the submission of these records.
I understand that charges incurred for additional services (i.e. legal forms, letters to school/employer, insurance/disability forms, record releases) cannot be billed to my insurance and that I am financially responsible for these charges.
I understand that by signing this, I am consenting to treatment for myself or dependent by AAWHA and/or any professional providing services on behalf of AAWHA.
I hereby give AAWHA office personnel permission to leave a message on my answering machine concerning my or my dependent's appointment time.
I have been given the opportunity to receive a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand the office has the right to change this notice at any time and I may obtain a current copy upon request.
I have received, reviewed and agree to the Office Policies of AAHWA.
I authorize medical information to be released to the following person/persons:

- Name: _____Relation: _____ Phone: _____
- Name: _____Relation: _____ Phone: _____
- Name: _____Relation: _____ Phone: _____

My signature below constitutes my acknowledgement that I have been provided with an opportunity to review the Privacy Practices and the above statements and I agree with the conditions thereof.

_____ _____
Signature Date

_____ _____
Guardian if Minor Date

_____ _____
Witness Date

Revised/2012-04-19 TMC

Responsible Party Insurance Information

Primary Insurance: _____

Insurance Subscriber: _____Date of Birth: _____

Relationship to Responsible Party: _____

Secondary Insurance: _____

Insurance Subscriber: _____ Date of Birth: _____

Relationship to Responsible Party: _____

Emergency Contact Information

Emergency Contact (Living outside of your home): _____

Relationship: _____ Phone Number: _____