Heartland Women's Healthcare

Consent for Treatment and the Use or Disclosure of Protected Health Information

Full Name: _____ DOB: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Cell) _____ (Work) _____

As required by the Health Insurance Portability and Accountability Act, Heartland Women's Healthcare may not use or disclose your protected health information without your authorization except as provided in our Notice of Privacy Practices.

I, _____, understand that my health information may be protected by the Federal rules for Privacy of Individually Identifiable Health Information and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand it is the policy of Heartland Women's Healthcare that all my appointments are confirmed one working day prior to my office visit. If no one is home, a message will be left on my answering machine/voice mail with the time of my scheduled appointment. I understand this confirmation process cannot be waived or declined by myself or any individual.

I understand it is a policy of Heartland Women's Healthcare that all patients who are pregnant be tested for sexually transmitted diseases including HIV and/or AIDS to safeguard the health of all unborn infants and the staff at Heartland Women's Healthcare and Labor and Delivery in the hospital and I authorize all testing at this time.

I understand that my records may contain information regarding my mental health, substance use or dependency, sexuality, and also may contain confidential HIV/AIDS related information. I further understand that by signing below, I am authorizing the release or exchange of these records for the purpose of treatment, and to my insurance for benefit management and claims administration, legal processes and subpoenas, mandated treatment referral, and/or to release physical records as requested by myself or my legal representative.

I understand I do not have to sign this authorization. I understand I may inspect or copy the protected health information to be disclosed by Heartland Women's Healthcare. I also understand that if, by my refusal to sign, I am preventing the billing of insurance, payment of charges, and/or endangering the life of an unborn child or a member of the Heartland Women's Healthcare office or hospital staff, non-emergency treatment may be refused. **If you refuse to sign this consent form, we will not be able to treat you.**

Except to the extent action has already been taken in confidence on this authorization, I can, at any time, revoke this authorization by submitting a written notice to the office of Heartland Women's Healthcare, 3408 Office Park Drive, Marion, IL 62959. Unless revoked, this authorization will expire one year from today on the following date:

Expiration Date (Month/Date/Year): _____

My signature below indicates that I have been given an opportunity to read the Notice of Privacy Practices and to have any questions answered before signing.

I authorize all treatment on behalf by Heartland Women's Healthcare, as well as the release of my protected health information as previously.

Signature _____ Date:_____

Signing Authority (if not patient):_____ Relationship:_____

Witness Signature: _____ Date:_____

Heartland Women's Healthcare

Authorization for Release of Information

I, _____, hereby authorize the following person(s) to receive any disclosures of my health information, including but not limited to my account charges and balances, exam findings, laboratory and ultrasound results

☐ **NONE**

1. _____ _____
   Name Relationship
2. _____ _____
   Name Relationship
3. _____ _____
   Name Relationship
4. _____ _____
   Name Relationship

I understand that I may alter or revoke, in writing, this authorization at any time. I further understand that any such alteration/revocation does not apply to any previously authorized use or disclosures of my health information, which have already been enacted in trust on this authorization.

I acknowledge, by my signature; I comprehend and understand the full scope of this authorization including any and all restrictions and/or permissions relegated within.

This authorization will expire on year from the date of my signature.

_____ _____
Signature Date

_____ _____
Witness Signature Date

_____
Authorization Expiration Date

Heartland Women's Healthcare

Patient Registration

Name: _____ _____ _____
First Middle Last

Address: _____

City: _____ State:_____ Zip: _____

Date of Birth: _____ Age: _____ Social Security Number: _____ - _____ - _____

Phone: (Home) _____ (Cell)_____ (Work)_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Employment Status: ☐Student ☐Employed ☐Retired ☐Unemployed

Referring Physician: _____ Pharmacy: _____
Name City

E-Mail Address: _____

How did you hear of us? Referral Newspaper Commercial Radio Friend Other:_____

PRIMARY INSURANCE
Please present insurance to the receptionist!

_____ _____
Card Holder's Name Relationship

_____ _____
Social Security Number Date of Birth

SECONDARY INSURANCE
Please present insurance to the receptionist!

_____ _____
Card Holder's Name Relationship

_____ _____
Social Security Number Date of Birth

Emergency/Alternate Contact

Name: _____ _____ _____
First Middle Last

Phone: (Home) _____ (Cell)_____ (Work)_____

I am required to present with current and complete insurance information & cards at each visit. If I present without this information I will be required to reschedule or pay at the time of service until valid insurance information is provided. Timely Filing Limitations for all insurance companies are applicable. If I do not provide Heartland Women's Healthcare with correct insurance information and the timely filing deadline passes, due to my failure to provide this information, or if my insurance company applies my services to a deductible, co-insurance, co-payment, or considers the services as non-covered, I accept total financial responsibility for all related charges, attorney fees, and/or collection agency fees incurred in the process of recouping my payment.

I have read, understand, and agree with the above information:

_____ _____
Signature (Patient or Parent if Minor) Date

Heartland Women's Healthcare

Insurance Policies

While there are 1000s of private venders as well as state and local government employers offering numerous insurance policies for our patients, Heartland Women's Healthcare strives to understand and stay apprised of as many of these insurance companies as possible along with their various merits. We attempt to pre-cert and/or pre-authorize all testing, and verify benefits for as many visits and procedures as possible. However, the responsibility for knowing your insurance ultimately lies with you, the patient. Below are some of the Heartland Women's Healthcare guidelines:

- It is the policy of Heartland Women's Healthcare to have all insurance cards presented at each visit/exam. It is a posted policy of Heartland Women's Healthcare that proof of insurance is required.

- It is the responsibility of the patient, not Heartland Women's Healthcare to know the details of their insurance policy and what is covered and/or non-covered by said insurance policy.

- It is the responsibility of the patient, not Heartland Women's Healthcare, to verify that the physician(s)/provider(s) of Heartland Women's Healthcare are IN Network with the patient's insurance carrier.

- If Heartland Women's Healthcare is not provided with the correct insurance information prior to or at the time of service preventing claims from being filed in a timely fashion, or if services are applied to a deductible, a co-insurance, a co-payment, or if the services are considered as non-covered, the total financial responsibility for all of the related charges will become the sole responsibility of the patient and the patient will assume total financial responsibility for all related charges, attorney fees, and/or collection agency fees incurred in the process of recouping those payments.

LIFETIME CONSENT/SIGNATURE

I authorize the release of all medical information necessary to process insurance claims(s) and I hereby assign and authorize direct payment of all medical and/or surgical benefits including major medical, private insurance, and other health plans to Heartland Women's Healthcare.

I request payment of authorized insurance payments be made on my behalf to Heartland Women's Healthcare for any and all services furnished to me by the providers of Heartland Women's Healthcare. 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 those benefits or the benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. (A signed photocopy of this assignment is to be considered as valid as an original.

_____
Printed Name (Patient)

_____
Printed Name of Guarantor (If Different than Patient)

_____
Signature (Patient)

_____
Signature of Guarantor (If Different than Patient)

_____
Date

Heartland Women's Healthcare

Authorization for Disclosure of Protected Health Information to Patient Portal

All sections of this form must be filled out completely or it will not be accepted.

I hereby authorize Heartland Women's Healthcare to use/disclose my individually identifiable health information to Patient Portal (which may include information concerning treatment for drug/alcohol abuse, mental health, HIV status, or genetic testing records, if applicable).

Name: _____
(Print) First Middle Last

Date of Birth: _____

Mailing Address: _____
(Print) Street or Post Office Box City State Zip

*E-mail address that patient portal message will be sent to: _____
** *An e-mail address is required for patient portal access*** Print

- I understand that my health care and the payment of my health care will not be affected if I do not sign this form.
- I understand that I MAY REFUSE TO SIGN THIS AUTHORIZATION. I also understand that Heartland Women's Healthcare shall not refuse to treat me if I refuse to sign this authorization.
- Heartland Women's Healthcare is not responsible for a breach of this information if the patient using the portal is using a computer workstation or device that could be compromised.
- I understand that this authorization MAY BE REVOKED in writing and delivered to Heartland Women's Healthcare 3408 Office Park Dr. Marion, Illinois 62959 at any time requesting that my account be inactivated.

_____ _____ _____
Date Signature of individual or representative Relationship

For office use only

☐ E-mail address entered in Emd's by_____on _____.
initials date

☐ Patient activated by_____on _____.
Initials date

☐ Verified email address
☐ Mailed user name and password to patient
☐ Form scanned into Emd's