

AUTHORIZATION/ACKNOWLEDGEMENT FORM

10031 Sherrill Blvd | Knoxville | TN 37932 | p: 865.540.1650 | f: 865.246.4755

Patient's Name: _____ Date of Birth: _____

ASSUMPTION OF REFERRALS:

I understand that if I have insurance coverage, which requires a referral from a Primary Care Physician, it must be received prior to being seen in order to receive the maximum benefits from the insurance company. I further understand that it is my responsibility to know my benefits and obtain a hardcopy referral from my Primary Care Physician. I have been given the opportunity by Contemporary Women's Health, PLLC to obtain a referral or reschedule my appointment. I understand that if I refuse that I am taking full responsibility for payment.

Initial: _____

AUTHORIZATION TO PAY INSURANCE BENEFITS TO PROVIDER:

I hereby authorize direct payment to the Physician of any hospital insurance benefits, medical insurance benefits, including Medicare, Medigap, major medical benefits, insurance disability benefits, or injury benefits. I am responsible to pay non-covered services. I also authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:

I have reviewed a copy of Contemporary Women's Health, PLLC Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by Contemporary Women's Health, PLLC and that I should read it carefully. I consent to Contemporary Women's Health, PLLC use of protected health information as described in the notice. I am aware that the Notice may be changed at any time. I may obtain a current copy of the Notice by calling (865) 540-1650 or by requesting one in person at the office.

Signature: _____ Date: _____

CONTACT NOTIFICATION:

Contemporary Women's Health, PLLC will leave confidential messages on your home and/or cell answering machine according to your instructions on the second page of this form. We will safeguard your privacy by limiting the amount of information disclosed. No abnormal tests results relayed by message.

Signature: _____ Date: _____