4470 Regency Place
Suite #105
White Plains, MD 20695

WALDORF
WOMEN'S CARE

Phone: 240.252.2140
Fax: 240.252.2141
info@waldorfwomenscare.com

HIPAA CONSENT

HIPAA AUTHORIZED PERSONS

I, (*please print your full name*)______________________________D.O.B____/____/____, give permission to Waldorf Women's Care to discuss my file, including medical and financial information, with the following individuals.

Waldorf Women's Care, LLC is a HIPAA compliant office. Therefore, our staff is restricted by the HIPAA rules and regulations in discussing the patient or the patient's medical information with only the patient, unless the patient has given us permission in writing to speak to someone else as well.

If you, the patient wish for us to have the ability to discuss your file, including any medical information or financial information, please designate the individual(s) below.

Name:__________________________________Relationship: __________________ Phone No._________________

Name:__________________________________Relationship: __________________ Phone No._________________

Name:__________________________________Relationship: __________________ Phone No._________________

VOICEMAIL AUTHORIZATION

☐ I give permission to Waldorf Women's Care, LLC to leave financial information, lab results, test results and other medical information on **my voicemail** if I am not available at the time of their phone call.

☐ I do not give permission to Waldorf Women's Care, LLC to leave financial information, lab results, test results and other medical information on **my voicemail** if I am not available at the time of their phone call. This this case, Waldorf Women's care will leave our name and number and request for you to call us back.

EMERGENCY CONTACT

****Emergency Purposes only!** ***No Personal Medical Information will be given to this person(s)*****

Name:_________________________________Relationship: ___________________Phone No._________________

Signature of Patient __________________________________ Today's Date _____/_______/________

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Office & Financial Policy

The providers at Waldorf Women's Care are here to serve your healthcare needs and are dedicated to providing you the best possible care. The intent of this policy is to clarify the role of the patient and the provider regarding billing issues. We ask that you ***carefully read*** and sign the following Financial Policy.

- **Our relationship is with you, the patient, not your insurance company**. Care will be administered to you based on medical necessity, not according to what is covered under your health insurance policy. Because there are numerous insurance companies that have many product lines, it is the patient's responsibility to know the benefits/coverage and requirements of their health insurance plan. Any questions regarding coverage and/or payments of claims should be addressed directly to your insurance company. This can be an overwhelming process so at any time you need help, we would be glad to assist you but ultimately it is your responsibility.
- **No Show Fee Policy.** Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand, and limited availability of appointments we have instituted a **$35 no show fee.** You must give 24-hour advanced notice to cancel appointments. Failure to do so will result in a $35 fee charged to your account.
- **Late.** If you are more than 10 minute past your appointment time you may be asked to reschedule your appointment.
- **You are responsible for informing staff of any address and insurance changes.** You will be expected to present current insurance information at each visit. If you have changed insurances, you must provide a copy of your new card. If you have lost coverage you will need to notify staff immediately. Failure to disclose this information will be reason to be discharged from the practice and/or a $250 fee and you will be billed for the full amount of the charge.
- **All co-pays and/or outstanding patient balances are due at the time of your visit**. If you are unable to pay your entire balance at the time of your visit, please see the billing department to set a payment plan before your actual appointment.
- **There is a finance charge of 2% each month your outstanding bill goes unpaid.**
- **Discharge of care.** Patients who do not make reasonable progress toward paying outstanding obligations to the practice may, at the sole discretion of the practice, be discharged from the practice. Furthermore, the practice may give the account to a collection agency, may sell the debt to a third party and may report the debt to a credit agency.
- **If you have Medicaid and another commercial insurance (Aetna, Carefirst Blue Cross/Blue Shield, Cigna, United Healthcare). The law states that the commercial insurance must be your primary insurance. You do not have the option of determining your primary insurance – the law does. It is fraud if you fail to disclose your commercial insurance and as such you will be discharged from the practice and all monies owed will be due immediately. You may also be charge a $250 fee.**
- **The provider that you see for your visit will determine the level of care and the diagnosis that applies.** If you are scheduled for a yearly well-women exam that includes treatment for a problem (vaginal discharge, abnormal bleeding, pelvic pain, etc), it will be billed as an additional problem visit which may require a copay.
- **Lab Tests and Other Charges.** If your visit includes lab tests, biopsies, pap smears or cultures you will receive separate billing from the company performing the processing and evaluation of those tests. It may take as long as 4 weeks to receive those bills. Please call those offices regarding the billing questions you may have, as we have nothing to do with that billing process. If you need to have your labs sent to a specific laboratory, please notify our providers before the test is performed.
- **Disability Forms.** There is a $20.00 administration fee in order to have your disability forms completed.

I understand and agree that insurance policies are an agreement between my insurance carrier and myself, not the provider. I understand that I am responsible for any balances my insurance company will not cover. I authorize Waldorf Women's Care to furnish information to insurance carriers concerning illness and treatments in order for reimbursements.

If I terminate or am discharged from care, any fees including reasonable fees allowed by Public Health Law for copying my medical records will be immediately due.

In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient.

________________________________ ______________
Patient Signature Date