



## Arbor Obstetrics and Gynecology Insurance Waiver

**PLEASE SIGN THE AUTHORIZATION BELOW SO THAT WE MAY INCLUDE THIS IN YOUR MEDICAL RECORD. YOUR SIGNATURE IS NEEDED ON ALL THREE LINES BELOW.**

I hereby authorize Arbor OB/GYN to release any information acquired in the course of my examination or treatment for processing insurance or upon my request.

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(Patient's Signature)

(Date)

I hereby authorize the direct payment of any benefits due for medical services. I fully understand that my insurance coverage is a contract between myself and the insurance company. I also understand that my coverage is subject to the terms and provisions of the contract and that ultimately I am financially responsible for payment in full for all charges incurred from services rendered by Arbor OB/GYN.

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(Patient's Signature)

(Date)

Many HMO/PPO policies require that diagnostic testing be performed by particular laboratories/facilities. We are usually given lists of the approved providers; however, we cannot guarantee that our lists are the current due to frequent changes. Please be advised that it is your responsibility to insure that we order your tests from an appropriate facility. Failure to do so may result in the claim being denied by the insurance company, which would leave you responsible for the bill. Should you need any test ordered (ultrasound, mammogram, amniocentesis, blood/lab work), please check with the insurance company regarding coverage, benefits, pre-authorization and/or referral.

Also, HMO/PPO insurance policies do not cover office visits for routine exams (not associated with a problem or illness). Some plans may allow some type of benefit for routine services, but this can vary depending on the provisions set up by YOU or YOUR EMPLOYER. As a courtesy to you, we will file for your HMO/PPO benefits if we are contracted with that company; however, if the insurance plans denies the charges we will bill you accordingly.

I agree to pay all charges incurred by me.

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(Patient's Signature)

(Date)

**SHOULD YOU HAVE ANY QUESTIONS REGARDING FEES PLEASE INQUIRE.**



**ARBOR OB/GYN, P.C.**  
 Samantha L. Anderson  
 9Dunwoody Park, Suite #108, Atlanta, GA 30338

**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_, am aware and understand that ARBOR OB>GYN creates and maintains my vital and clinical records such as medication, symptoms, diagnoses, history, physical exam, test results consultation discussions for my current and future treatment. This information is protected and kept confidential to the extent that the federal and state laws allow under the Health Insurance Policy and Accountability Act of 1996 (HIPPA) and Arbor OB/GYN will provide me with the full notice of Privacy Practices upon request.

I understand that ARBOR OB/GYN may use and disclose my records for the following:

- Treatment- such as, but not limited to- using records or test results in prescribing medications; disclosing information to the pharmacy when ordering prescriptions for you; ordering laboratory testing; using those tests to reach a diagnosis; disclosing your information to other health care providers who may assist in your treatment.
- Payment. Our practice may use and disclose information in order to bill and collect payment for services rendered in our office. We may contact your insurance to verify that you are eligible for specific benefits and we may provide your insurer with details of your treatment to determine if your insurer will cover or pay for your treatment.
- Health Care Operations. Our practice may use and disclose your information to evaluate the quality of care you receive in our office or to conduct cost-management and efficiency planning for the office.

I understand that I have a right to request in writing that Arbor OB/GYN communicates with me about my health and related issues in a particular manner or at a certain location- such as contacting me at home instead of work. I understand that I must be specific in the method and location of contact in order to accommodate my request and that Arbor OB/GYN will accommodate **reasonable** requests. I do not need to give a reason for the request. Furthermore, I understand that I may request in writing certain and specific restrictions in the disclosure of my information to friends and family members involved in my treatment. I may request that certain individuals be privy to my information or I may request that certain and specific information be withheld from them. **Arbor OB/GYN is not required to agree to my request**; however if they do agree, they are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat me.

I understand that I have a right to review the formal notice of Privacy Practices before signing this consent. I understand that I may revoke this consent in writing except to the extent that Arbor OB/GYN has already acted. I also understand that by refusing to sign this consent or by revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations.

I understand that Arbor OB/GYN reserves the right to change their notice and practices prior to implementation in accordance with section 164.520 of the Code of Federal Regulations. Should Arbor OB/GYN change their notice, they will provide a copy of the revised notice upon request.

I fully understand that by signing below I **ACCEPT** the terms of this consent.  
 If I choose to **DECLINE** we may refuse treatment as permitted.

\_\_\_\_\_  
 Patient /Guardian Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Patient Name (please print)

- Consent received by \_\_\_\_\_ on \_\_\_\_\_
- Consent refused by patient and treatment refused as permitted