DOTHAN OBGYN

UNCOVERED LAB ACKNOWLEDGEMENT

I acknowledge that my physician performs certain tests that he/she believes are in the best interest of women's healthcare. I understand that he/she may recommend routine and periodic screenings and tests. Some screening tests may not be covered by my insurance. If my insurance does not pay for certain services, I will be responsible for the payment of services. In addition, I may receive a separate bill for any lab work processed by a third party.

CONSENT FOR TREATEMENT

I authorize Dothan OBGYN to perform treatment that, in the physician's professional judgment is deemed appropriate. I hereby authorize Dothan OBGYN to release any information acquired in my examination or treatment to any insurer, government agency providing benefits, or anyone for charges. Additionally, I give my permission to allow my healthcare provider to obtain any and all history from my pharmacy, my health plans, and my other healthcare providers.

PRIVACY PRACTICES

I have received, read and understand Dothan OBGYN's privacy practices containing a more complete description of the uses and disclosures of my health information. I understand that this Practice has the right to change its Notice of Privacy Practices at any time. I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I authorize notifications such as appointment reminders to be sent to my cellular phone.

INSURANCE ASSIGNMENT

I hereby assign to and authorize payment to Dothan OBGYN of all benefits payable under the terms of any insurance policy listed on file. I realize the insurance may not pay the entire bill. I agree to pay the difference or the entire bill if necessary. I understand that I fail to make any of the payments for which I am responsible in a timely manner, such default may be referred to a collection agency or attorney.

COLLECTION/ATTORNEY FEES

If my account is turned to a collection agency, I accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I understand in order for Dothan OBGYN and/or its agents to service my account or collect monies I may owe, I consent to be contacted at any telephone number associated with my account, including any wireless telephone numbers, which could result in charges to me. I also consent to be contacted by text message or email, using any email address provided by me. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

MY SIGNATURE CONFIRMS MY UNDERSTANDING OF THE ABOVE PRACTICES AND MY CONSENT TO EACH:

_____ _____

PATIENT/REPRESENTATIVE SIGNATURE DATE