Lakeland Premier Women's Clinic

Patient Authorization & Privacy Policy

Please initial:

____ **Authorization to Release Medical Information:** I hereby authorize Lakeland Premier Women's Clinic to furnish any medical information necessary to process insurance claims. I permit a copy of this authorization to be used in place of the original.

____ **Authorization to Pay Benefits to Physicians:** I hereby assign Lakeland Premier Women's Clinic all insurance including Medicare and Medicaid payments otherwise payable to me for service(s) rendered, but not to exceed my indebtedness to the above. It is understood that any money received from the insurance company(s) over and above my indebtedness to the clinic will be refunded to the appropriate party (me or the insurance carrier) when my bill is paid in full.

____ **Consent for Treatment:** The undersigned authorizes the physician assigned to furnish medical and/or surgical treatment by those means he considers necessary and proper in treatment of the patient identified below while a patient at Lakeland Premier Women's Clinic. This treatment may require additional diagnostic procedures including but not limited to lab tests, blood drawing for those tests, and ultrasounds.

____ **Medicare:** The physicians at Lakeland Premier Women's Clinic are in participation with Medicare Part B. Benefits will be assigned and paid to the provider of services. Patients will be responsible for the deductible and any co-insurance amounts not paid by supplemental policy. Medicare patients may be asked to sign a waiver for any series not deemed medically necessary by Medicare.

____ **Medicaid:** The physicians at Lakeland Premier Women's Clinic, accept Medicaid.

I request that payment of authorized Medicare/Medicaid benefits be made to my physician. I authorize the holder of medical or other information about me to be released to HCFA/Division of Medicaid and its agents and any other information needed to determine these benefits or the benefits payable for related services.

____ **Notice of Privacy Policy:** I have been given the opportunity to review a copy of Lakeland Premier Women's Clinics' Notice and Privacy Policy.

____ Our practice participates in prescribing via our electronic medical record (EMR) which has achieved Certification Commission for Health Information Technology (CCHIT) certification. Electronic prescriptions are submitted to the pharmacy designated by the patient.

Appointment Reminder Preference: Circle all that you prefer: Voicemail Email Text

Preferred Method: *Home Cell*

I have read each of the marked statements above. I understand the contents that I have read and agree to the terms thereof.

Patient's Printed Name: _____ Date: _____

Patient's/Authorized Representative's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____