
Authorization for the Use and Disclosure of PHI

Use and Disclosure of Health Information

I _____ hereby authorize the use or disclosure information as follows:
PRINT NAME

All health information pertaining to insurance payment, treatment, medical history, and mental or physical condition.

Purpose of request use or disclosure: Continuation of treatment.

Expiration

This Authorization expires **one year** from the date of signing.

Notice of Rights and other information

I may refuse to sign this Authorization.

Understanding that by doing so, Carolina Conceptions will not be responsible for filing any claims to my insurance provider on my behalf. I may revoke this authorization at any time.

My revocation must be in writing, signed by me or on my behalf;

and delivered to the following address: 2601 Lake Dr., Suite 301, Raleigh, NC 27607

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance up this Authorization.

I have a right to receive a copy of this authorization.

Neither treatment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law. (HIPAA).

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Signature _____ Date _____

CONSENT TO TREATMENT

I hereby voluntarily consent to outpatient care at Carolina Conceptions. Such care includes routine diagnostic procedures, which includes but is not limited to routine laboratory work (such as blood, urine and other studies) and ultrasounds. Such care also includes examination and medical treatment with administration of medications. Routine laboratory testing may include testing for HIV, the virus that causes AIDS. I understand that I have the option to decline testing for HIV and will notify the staff if I choose to decline testing.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Carolina Conceptions.

Signature: _____

If signature is not that of the Patient, indicate below the relationship of the person signing for the (e.g., Parent, Guardian): _____

If patient or patient's personal representative does not sign, indicate the reasons why signature could not be obtained: _____

Name of Practice Staff Member

Date



INSURANCE DISCLAIMER

Insurance Coverage. The health insurance and medical industry is becoming increasingly complex. Each patient has a unique bundle of insurance coverage (HMO versus PPO, copays, lab copays, deductibles, exam coverage, etc...). We are happy to assist you in understanding your specific insurance benefits and responsibilities. Any changes in your insurance plans or benefits can affect your coverage for your visits as well as any pending visits or diagnostic tests. Please be aware that due to the large variety of medications offered we are unable to verify coverage for prescriptions, as we are a medical services provider not a pharmacy. You may contact your insurance plan to obtain benefit coverage for medication. We encourage you to notify the office of any insurance changes. With out notification we are unable to verify coverage and benefits. Ultimately, you are responsible.

Proof of insurance coverage is required at the time of the office visit. Without confirmation of benefits, you will be charged full price for the office visit. Insurance benefits will not be applied retroactively.

Referrals. It is your responsibility to make certain that the referral is obtained prior to your specialist appointment if one is required by your insurance. Without the proper referral paperwork, you may be 100% responsible for your specialist visit. All referrals must be completed prior to a specialist visit.

Billing. We expect full payment of copayments, deductibles and non-covered expenses prior to leaving the office visit. Insurance claims will be filed to your primary insurance; we do not file to secondary. The insurance company will send you a detailed EOB (explanation of Benefits) after they have processed the claim. The EOB explains the charges, the discounts, the insurance payment to the doctor and the patient's responsibility for all coinsurance, deductible or copays. We will bill you for any outstanding patient balance. Payment is expected within 30 days.

Thank you for choosing Carolina Conceptions for your infertility needs. We hope this provides a better understanding of our financial department.

Print Name: _____

Signature: _____ **Date:** _____