Comprehensive Women's OB/GYN
A Division of Atlanta Women's Health Group, P.C.

11 Dunwoody Park
Suite 100
Atlanta, GA 30338
Telephone (770) 730-0451

3630 Savannah Place Drive
Building 100, Suite B
Duluth, GA 30096
Telephone (678) 474-0203

PATIENT NOTICE

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996(a federal law). Of significant concern to healthcare organizations is the Administrative Simplification Section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

I authorize Comprehensive Women's OB/GYN to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home telephone	Yes _____	No _____	Tel.#: _____
Answering machine at home	Yes _____	No _____	
Work telephone	Yes _____	No _____	Tel #: _____
Voice mail at work	Yes _____	No _____	
Cell phone/cell phone voice mail	Yes _____	No _____	Cell #: _____
E-mail	Yes _____	No _____	E-mail address: _____

Please provide your pharmacy telephone number (Please Note: It is important that we get the correct number so we can send your prescription directly to the pharmacy. If a number is not provided, it will slow down the process to getting your prescription sent. We will not be able to find your pharmacy with name/location only.

Pharmacy Name: _____ Telephone#: _____

Please list names of people we can discuss your medical care with, in case of an emergency:

Name	Yes	No	Relationship	Phone number

_____ _____

Signature Patient/ Guardian Date

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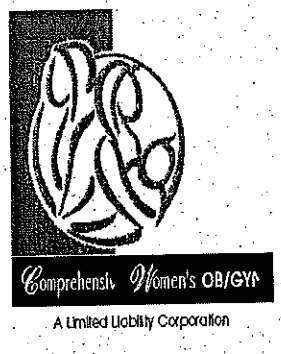
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

Patient Name: _____ Account # _____
To Be Completed by Staff

- I understand that I can request restriction on how my health information is used or disclosed to carry out treatment or health care operation. However, there may be time when Atlanta Women's Health Group, P.C., is not able to honor my request restrictions. For example, they may need to release my medical information to get paid from an insurance company or to treat me.
- I consent to the disclosure of my protected health information for the purpose of medical diagnosis, providing treatment, obtaining payment, or to conduct necessary health care operation, and authorize direct payment of medical insurance benefits to Atlanta Women's Health Group, P.C., for service performed. I also understand and agree that I am responsible for payment of all valid charges not paid by my medical insurance.
- I accept that there is no guarantee of protection of my medical record from a court order release. In the event of legal proceedings involving patient care, I understand the contents of my file must be made available to legal counsel representing the practice and professional employee.
- I have received a copy of Atlanta Women's Health Group's, Notice of Privacy Practices on the date listed below, and have been advised that I will be notified of any changes at future office visits. I may obtain a current copy by visiting the Web Site **www.AWHG.yourmd.com**.

_____ _____
Patient Signature/Personal Rep **Date**

_____ _____
Print Patient Name/Personal Rep **Personal Representative's Authority**



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Comprehensive Women's OB/GYN Financial Disclosure Statement

Thank you for choosing Comprehensive Women's OB/GYN. Please read and sign this Financial Disclosure Statement prior to your appointment.

Some insurance plans require you to pay different out-of-pocket amounts including deductibles, co-insurance and co-payments according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. All payments are due before services are rendered. The amount paid at the time of your appointment is only the physician fee. If any other test is ordered like an Ultrasound or Biopsy, the office will verify benefits with your insurance before services are rendered and you will be responsible for any payment at the time of your appointment.

Please note that Labs are **NOT** included in the amount paid at the time of your appointment. If any labs are ordered, you will receive a bill from the lab. This includes blood work, urine cultures, vaginal cultures, biopsies, pap smears, etc.

_____ PRINT PATIENT NAME

_____ PATIENT SIGNATURE/GUARDIAN

_____ DATE

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APPOINTMENT POLICY

In order to better serve our patients, we set aside specific times for our patient's appointments. If you do not show for your appointment or cancel with less than 24 hours notice, a fee of $25.00 is subject to be charged to your account. ***This cannot be billed to your insurance; you will be responsible.*** You will not be allowed to reschedule your appointment until this fee is paid. By utilizing this policy, we are able to provide medical care to those who are awaiting appointments.

You will receive a courtesy phone call two days in advance to confirm all scheduled appointments. If you are unavailable, a message will be left indicating the date and time of your appointment.

This appointment policy will be enforced with the exception of true emergencies.

I have read and understand the above policy. I understand that if I violate this appointment policy, $25.00 will be billed to my account and must be paid before any future appointments are made.

_____ _____

Print Patient Name Patient Signature/Guardian

_____

Date