COVINGTON
WOMEN'S HEALTH
SPECIALISTS
4181 Hospital Drive, NE, Ste. 101 & 104 Covington, GA 30014
5154 Cook Street, Covington, GA 30014
770-385-8954

Consent for treatment

_____I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

_____I understand that medicine is not an exact science and no guarantees have been made as to the results of the treatment or care rendered.

____ I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

____I consent that any photos submitted to our office may be used in social media advertising and/or printed publications.

____I consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

____I consent and authorize Covington Women's Health Specialists, LLC to use and disclose any medical information deemed necessary and without restriction.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____
PRINT NAME DATE

_____ _____
SIGNATURE WITNESS

COVINGTON WOMEN'S HEALTH SPECIALISTS
4181 Hospital Drive, NE, Ste. 101 & 104 Covington, GA 30014
5154 Cook Street, Covington, GA 30014
770-385-8954

Financial Policy

Covington Women's Healthcare Specialists, LLC is pleased to provide your medical care. Please read our Financial Policy. If you have questions or concerns, our staff will be happy to assist you.

Financial Policy:

- As a patient at Covington Women's Healthcare Specialists, LLC you assume personal responsibility for your account with us.
- Medical insurance is a contract between you and your insurance company. It is your responsibility to know limitations exclusions, deductibles, and co-pays of your insurance plan and to resolve any disputes with your insurance carrier for nonpayment of services. As the insurance policy holder, you are responsible for timely payment of your account for any unpaid balances as indicated by your insurance.
- As a courtesy to you, we will file your insurance claims for our services. Even though every effort will be made to collect from my insurance carrier, the ultimate responsibility for charges is mine.
- By law, we are required to collect your co-payment at each visit.
- We will collect your co-payment before you see the provider at each visit.
- If you have a deductible, it must be paid at the time of visit.
- If during your annual visit, you discuss issues with the provider that are problems not preventative, which require discussion and evaluation above and beyond your annual care, you could be subject to a co-pay.
- Depending on your coverage, you may be required to pay a percentage of the visit charge at the time of your visit.
- For services not covered, payment is required at time of the service. For example: Infertility Diagnosis
- There is a thirty five dollar ($35.00) fee for checks not honored by your bank in addition to the amount of the check.
- We do not re-deposit checks.
- Balances over ninety (90) days old may be placed with our attorney or collection agency. All fees charged by the attorney or agency will be added to your balance (15%)
- To cover electronic payment processing of your credit card payment, a 3% fee will be added to all credit card transactions. For example, a $20 co-payment will be charged as $20.60.

PLEASE READ CAREFULLY:

I hereby authorize Covington Women's Healthcare Specialists, LLC to furnish information to insurance carriers concerning my visits, illnesses and treatments and I hereby authorize direct payment of medical benefits to Covington Women's Health Specialists, LLC for services rendered to myself or to my dependents. I understand that I am financially responsible for any balance not covered by insurance. If my Medicaid, Peachstate, Wellcare, Amerigroup, CareSource or any other insurance is terminated during the time of my date of service, I will be billed and held financially responsible for the balance. Failure to pay may result in collection actions as described above and future appointments being cancelled and/or being terminated from the practice.

I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement. I agree to provide the above practice and/or its designated payment agent with debit/credit card or ACH information.

I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.

If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information

I have read and understand these Policies and Consents. By signing this consent, I acknowledge that I have been offered a copy of this consent form.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Print name Witness