Affordable Care Act

Name:

Preventative Care

Most insurance companies cover preventative care services at 100%, meaning there are no out-of-pocket costs for these services. Preventative care includes routine check-ups, such as physical exams (including pelvic and breast exams), as well as screenings like Pap smears for cervical cancer, HPV testing, and contraception counseling. These services are designed to maintain your health, detect potential issues early, and support your overall well-being. Preventative visits are focused exclusively on prevention and proactive health care.

Non-Preventative Care

If additional health concerns are addressed during a preventative care visit, the nature of the visit may change. Non-preventative care includes the diagnosis or treatment of specific symptoms or conditions such as bleeding issues, hormonal concerns (including menopause or PMS), urinary issues, infertility, vaginal discharge or itching, and other concerns unrelated to preventative care. These services are typically subject to your insurance plan’s copay, coinsurance, or deductible requirements. As a result, insurance companies may no longer classify the visit as preventative, and the associated costs could become the patient’s responsibility.

*Our Commitment to Your Health*

Your health and well-being are our top priority. We are committed to addressing all your health concerns thoroughly and ensuring you receive the care you need. To comply with insurance rules on what they will cover, some issues may need to be addressed in a separate visit. This approach ensures you maximize your health insurance benefits while keeping your out-of-pocket costs as low as possible.

If you have questions about your coverage or benefits, we encourage you to contact your *insurance provider* for more details. We are here to support you in navigating your healthcare journey.

Authorization for the Use and Disclosure of Protected Health Information (PHI)

I, , consent to County Obstetrics & Gynecology using or disclosing my protected health information (PHI) for treatment, payment, or healthcare operations. I understand that diagnosis or treatment may depend on this consent.

I have the right to request restrictions on how my PHI is used or disclosed, but County Obstetrics & Gynecology is not obligated to agree unless they have already acted in reliance on this consent.

PHI includes health and demographic information related to my past, present, or future physical or mental health that identifies me or could be used to identify me. I authorize payment of allowable benefits directly to County Obstetrics & Gynecology for services and consent to electronic claim filing.

I acknowledge receipt of County Obstetrics & Gynecology Notice of Privacy Practices, which outlines how my PHI may be used or disclosed, my rights, and County OBGYN's responsibilities. I understand that County OBGYN may update its privacy practices, and any changes will be outlined in the revised Notice of Privacy Practices.

[ ]  I authorize County Obstetrics & Gynecology] to disclose information solely for the following purposes:

* Treatment Coordination: To healthcare providers directly involved in my care.
* Billing and Insurance: To insurance providers or third-party payers for the purposes of billing, claims processing, and payment verification. The information disclosed for billing purposes may include: Diagnosis codes, Service dates, treatment plans, and other information required for clams processing.

[ ]  I understand that my treatment, payment, enrollment, or eligibility for benefits is not conditioned upon signing this authorization. I also understand that information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected under federal privacy laws.

[ ] I authorize the following individuals to receive my health information from representatives of County Obstetrics and Gynecology:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | First and Last Name |       | Relationship: |       |
| 2 | First and Last Name |       | Relationship: |       |

[ ]  I understand that information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy regulations.

Billing

[ ]  I authorize payment of medical and surgical benefits directly to my doctor.

[ ]  I understand that I am financially responsible for charges not paid for by my insurance.

[ ]  In the event of non-payment for 30 days, a $5 statement fee will be applied to your account. You will be responsible for any collection and legal fees associated with the collection of the balance due. The collection fee is 25% of the total balance turned over to an outside agency. All care will be terminated if your account is turned over to collections.

