SEEBABY

Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone:_____e-mail_____

Address: _____

City: _____ State: _____ Zip: _____

I authorize the use or disclosure of the above named individual's health information as described below.

1. Means to Disclose Healthcare Information

I do wish to have the availability to have any portion of my medical record submitted to me by all and/or the following below:

- ___US Postal Mail Service
- ___ Personal Email **(Listed on account only)**
- ___ Spouse of Patient _____
- ___ All of the above

Note: Faxed copies of records are prohibited as we are unable to guarantee full confidentiality of the medical record.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health records
_____ Lab results/X-ray reports
_____ Physical exam
_____ Consultation reports
_____ Immunization record
_____ Other (please specify: _____

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

3. *This information may be disclosed to and used by the following individual or organization.*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

For the purpose of: _____

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.

5. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed.. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact See Baby's office manager at 404-223-9306.

_____ _____

Signature of patient or legal representative

Signature of witness

Date: _____

Date: _____

Dear Patient:

Physicians have always protected the confidentiality of health information of their patients taking steps to do so such as keeping records under lock and key and refusing to disclose health information measures. Today, state and federal laws also seek to ensure the confidentiality of sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. . This "privacy rule" protects the health information that is maintained by physicians, hospitals, other health care providers and health plans. Since April 14, 2003, his doctor has had to meet the standards of this privacy rule to protect the confidentiality of health information.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to a hospital, fill a prescription or send a claim to your health plan, your doctor, hospital, and health plan will need to consider the rule privacy. All health information including paper records, oral communications, and electronic formats (such as email) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to their medical records. However, there are certain exceptions; these rights are not absolute. In addition, we will be taking even more precautions in our office to safe guard your health information such as training our employees and employing computer security measures. Please feel free to ask your physician or our privacy contact about exercising your rights or how your health information is protected in our office.

The Notice of Privacy Practices described in this letter explains our privacy practices and is available upon request. It contains very important information about how your protected health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information. Please let us know if you have any questions about our Notice of Privacy Practices.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I am aware of the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Signature _____

Date _____

Financial Policy for Medical Services

Insured Patient Policy

It is with great pleasure that we welcome you to SEE BABY, LLC. We are firmly committed to ensuring that our patients "Experience Excellence" while in our care. In order to do so, we must clearly outline our financial policy.

As a new patient it is necessary that you provide us with information regarding your insurance coverage. As per our contractual agreement with your insurance carrier, it is also necessary to present your insurance card at the time of service. Additionally, often times, a referral is required for a specialist visit. Please check with your referring provider's office as they will assist you with obtaining a referral authorization should one be required.

Prior to your visit, our office will verify your coverage benefits to assess any patient responsibility amount. These amounts are typically co-pays, co-insurance, and/or deductibles. Any patient responsibility amount is due at the time of service. An exception would be any co-insurance amount. Our office will balance bill this amount once your claim has been processed by the insurance company.

PLEASE NOTE: **Prior to appointment it is necessary for the patient to confirm policy benefit coverage specific to Maternal Fetal Medicine services. As the patient, you should be certain that your maternity benefits include maternity services that are billed as a Fee for Service claim. Given our clinical obligation to provide you the most thorough and accurate examination, please note that there may be occasions where our clinical expertise will lend to providing services not previously scheduled, and you are entrusting SEE BABY to make this decision on your behalf.**

Forms of Payment

Our office accepts the following forms of payment:
Cash, Visa, MasterCard, American Express and Discover.

Self- Pay Patient Policy

For those patients who must cover services via out of pocket expense, we do offer a Self-Pay Plan that is designed to meet the needs of patients with full or partial out of pocket expenses. You will find our Self-Pay Plan has very competitive rates, and affords all patients the opportunity to "Experience Excellence" at SEE BABY, LLC.

Should you need further information regarding our financial policy and or have a need for special payment arrangements, please do not hesitate to contact our office.

I have read, understand, and agree to the above Financial Policy.

Patient Signature _____Date_____

Printed Name _____

SEEBABY

Financial Lab Disclaimer

Please be advised that it is the responsibility of our patients to understand your insurance policy plan with regard to covered lab services as well as in and/or out of network provisions for labs. Therefore, when lab testing is recommended, See Baby reserves no responsibility in terms of understanding covered Lab services, or in and out of network plan provisions. If for any reason your lab is not covered, the sole responsibility of payment to the lab will be that of the patient.

As time permits, please check with your insurance carrier prior to obtaining lab work.

I HAVE READ THE ABOVE CONDITION AND AGREE TO THEIR CONTENT

Signature: _____
Relationship to patient: _____
Date: _____

Financial Lab Waiver
For
Spouse/Father of Baby

Our doctor is requesting for your spouse/FOB _____to obtain lab work. In the event that your insurance carrier does not cover test ordered, you agree and acknowledge full responsibility for payment to laboratory processing the lab order.

Signature: _____
Relationship to patient: _____
Date: _____