



Patient Name: _____
Birth Date: _____

I. Consent and Authorization for Release of Information

1. Release of Information. I consent to the release and use by Women’s Health & Laser Aesthetic Center, herein after referred to as WHLA, of medical and other information about me to the extent permitted by law to the following:

To a health care provider being advised or consulted in connection with my treatment or care;

To a health plan, insurer, third party payor, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews; and

To a person or organization in connection with WHLA’s health care operations. These operations may include interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, and other related activities.

To a person or organization in connection with WHLA for the purpose of medical research. All medical research involving the use and disclosure of health records must receive prior review and approval by an Institutional Review Board, who is charged with the protection of research subjects and the responsible conduct of research.

To the following individuals (name spouse or family member, coach, trainer, employer or others) as listed below:

Revocation. I understand that this consent is valid for one (1) year, unless I revoke it at an earlier date, which I may do at any time by giving written notice to WHLA.

II. Payment Authorization

1. Payment Responsibility. I agree to pay for all services furnished to me by WHLA, including, but not limited to, charges that are not paid in full by my insurance, government program benefits or other third-party payers, upon receipt of a statement, except as prohibited by WHLA’s contract with my health plan or applicable law. I also agree to pay or reimburse WHLA for all costs it may incur in collecting such amounts, including, but not limited to, attorneys’ fees and collection agency fees.
2. Payment Authorization. I authorize WHLA to directly bill my health plan or third-party payer for services rendered to me by or on behalf of WHLA, but acknowledge that WHLA is not obligated to submit claims to third-party payers on my behalf unless required by law or by its contract with a particular third party payer. I also authorize any third-party payer through which I may have benefits to make payment directly to WHLA for such services. If I have a Medigap policy, I request that payment of authorized Medigap benefits be made to WHLA directly on my behalf by my Medigap insurer. I understand and agree that WHLA is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf.
3. Statement to Permit Payment for Medicare Benefits to WHLA If I am entitled to Medicare benefits, I request payment of authorized Medicare benefits to me, or on my behalf to WHLA, for any services furnished to me by or in WHLA, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

III. Notice of Privacy Practices

1. Confidentiality. It is the policy of WHLA to protect the privacy and confidentiality of patients’ medical information.
2. Notice of Privacy Practice. WHLA’s Notice of Privacy Practices explains how WHLA may use and disclose my medical information. It also explains my rights regarding this kind of information. WHLA may revise its Notice of Privacy Practices at any time and will provide me with a copy of the revised Notice of Privacy Practices at my request. WHLA’s Notice of Privacy Practices is available at the reception desk.
3. Acknowledgment of Receipt. I acknowledge that I have received WHLA’s Notice of Privacy Practices.

Patient’s Name: _____ Date of Birth: ____/____/____ Account ID: _____

Signature of Patient (if applicable): _____ Date: _____

Signature of Legal Guardian (if applicable): _____ Date: _____