Women's Health
& Laser Aesthetic Center

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 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 the following individuals (name spouse or family member, coach, trainer, employer or others) as listed below:
_____
I understand that this consent is valid indefinitely while I am under care of WHLA.

II. Payment Authorization and Financial Acknowledgement

1. Payment Responsibility. I agree to pay in full at my visit for all services furnished to me by WHLA. 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. We accept cash, check, debit and major credit cards. We accept HSA card payment if your care is considered acceptable by your insurance provider. There is a $30 fee for any returned or bounced checks.

III. Insurance and non-covered services.

We do not participate in insurance plans, and do not party to the contract between you and your insurance company.

IV. 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 PRINT: _____ Date of Birth: _____/_____/_____

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

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