Intown Midwifery
PATIENT'S CONSENTS

Intown Midwifery
340 Boulevard NE, #103
Atlanta, GA 30312
Ph: 404-622-9810
Fx: 404-522-8129

FINANCIAL POLICY

I understand my insurance policy is a contract between my insurance company and myself, and that I am ultimately responsible for the entire bill. The only exception to this is an approved worker's compensation claim, and that should my worker's compensation status be reversed, that I am then responsible for the entire bill. I understand that the fees are based on treatment received and have no bearing on outcome. I also understand there may be a charge for appointments missed or cancelled less than 24 hours prior to my appointment time.

I understand Intown Midwifery's Financial Policy

x_____

AUTHORIZATION TO PAY FOR PROFESSIONAL SERVICES RENDERED

I hereby authorize payment directly to Intown Midwifery of the benefits for professional services rendered, otherwise payable to me as determined by my insurance company, but not to exceed the fee as finally determined by my provider. I understand that I am financially responsible for any professional charges not paid by my insurance company to Intown Midwifery

I understand Intown Midwifery's Professional Services Rendered Policy

x_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of a Notice of Privacy Practices from Intown Midwifery. I understand that Intown Midwifery may, at its discretion, change the terms and conditions of this notice. I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request.

____ Notice given to patient ____ Patient declined copy of notice

x_____

AUTHORIZATION TO LEAVE MESSAGES IN MY ABSENCE

I give Intown Midwifery permission to leave a message on my answering machine or with the following family members regarding reports, or blood work in my absence if I am not home when they call.

Initials _____ Leave lab information with _____

CONSENT TO TREATMENT

I consent to general treatment, medical procedures, and medications prescribed by Intown Midwifery. I understand the physicians and staff of Intown Midwifery will not discuss my health information with my family or friends unless I expressly authorize them to do so.

X_____

AUTHORIZATION TO REQUEST MEDICAL RECORDS

I hereby authorize _____ to release copies of my medical records to Intown Midwifery for the purpose of evaluation and treatment of my current condition

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Intown Midwifery to release any medical information, including confidential information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS, necessary to process insurance claims or any medial information that is needed for any utilization review or quality assurance activities

X_____