FINANCIAL POLICY

Please verify you insurance coverage and bring your current insurance card with you at the time of each visit. It is the responsibility of the patient to know your insurance coverage. It is also the responsibility of the patient to obtain a referral if one is needed. If a patient does not provide the necessary referral or authorization the financial responsibility becomes that of the patient's. At each visit, full payment is due, unless you are enrolled in a health care plan in which Saint Louis Associates in OB/GYN, Inc is also a participant. The following are accepted forms of payment for services provided: Visa, MasterCard, Discover, debit cards, checks, and cash. All payments are to be made prior to your scheduled visit to the receptionist. Do to our Providers being specialists; your insurance may require co-payments for each office visit. If a patient is to pay in excess of their due balance, no credits will be issued to the patient's account until all claims have been adjudicated and have been fully processed through the patient's health care plan. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment.

SIGNED (Patient or Guardian)____**DATE**____________________

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information (PHI)

Your protected health information will be used by Saint Louis Associates in OB/GYN, Inc., or disclosed to others for the purposes of treatment, obtaining payment, or supporting daily health care operations of this practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information (PHI) may be used and/or disclosed. You may review the notice prior to signing this consent.

The Right to Restrict the Use or Disclosure of Your PHI

You may request a restriction on the use or disclosure of your protected health information. Saint Louis Associates in OB/GYN, Inc. may or may not agree to restrict the use or disclosure of your protected health information. If Saint Louis Associates in OB/GYN, Inc. agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction constitutes a violation of federal privacy standards.

Revocation of Consent

You may revoke this consent regarding the use and disclosure of your protected health information (PHI). This must be in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Amend Privacy Practices

Saint Louis Associates in OB/GYN, Inc. reserves the right to modify the privacy practices outlined in this notice.

Signature

I have reviewed this consent form and give my permission to Saint Louis Associates in OB/GYN, Inc. to use and disclose my health information in accordance with it. Furthermore, I authorize Saint Louis Associates in OB/GYN, Inc. to release any medical or billing information, deemed necessary and/or requested by my health insurance companies, to process my claims. I assign payment of benefits for medical services to Saint Louis Associates in OB/GYN, Inc. I am responsible for all charges incurred and this is not affected by the fact that I have insurance benefits. Should my insurance company fail to pay any portion of these charges, I will be responsible for all sums owing. In addition, I agree to pay any additional charges related to the cost of collection (including, but not limited to, collection agency, attorney fees, and court costs) in the event that I fail to pay my bill. With regard to pregnancy and other health matters, I hereby authorize Saint Louis Associates in OB/GYN, Inc. to furnish a copy of my pre-natal records and/or other pertinent records to any hospital, agency, or ancillary facility deemed necessary by my physician. *If applicable,* I hereby give my permission for the providers at Saint Louis Associates in OB/GYN, Inc. to evaluate, diagnose, and treat my minor daughter as medically indicted.

______________________________________ ___________/_____________/_______________

Signature of Patient (Please Print) Date (mm/dd/yyyy)

Consent to Communicate

I hereby give Saint Louis Associates in OB/GYN, Inc my permission to contact me or leave messages on the following (choose those that apply):

Home ( )_______-____________ Cell ( )_______-____________ Other ( )_______-____________

I hereby give Saint Louis Associates in OB/GYN, Inc my permission to release any or all of my health information to the following person(s). I will not hold Saint Louis Associates in OB/GYN, Inc liable for any information released.

Name of Person to Release Information to (PLEASE PRINT)	Relationship to Patient	Contact Number
		(______)______-___________
		(______)______-___________
		(______)______-___________

____ ________/_________/_____________

SIGNATURE OF PATIENT Date mm/dd/yyyy