CORNERSTONE
CLINIC FOR WOMEN

Consent to treat and Notice of Privacy Practices

CONSENT: I voluntarily consent to receive medical and healthcare services from a Cornerstone Clinic for Women clinic. I understand this may include services by my physician, his or her assistants and designees, including medical students, residents or fellows, and employees of Cornerstone Clinic for Women as is deemed necessary or advisable in their judgment. I authorize the use of telehealth services, photographs, camera surveillance and/or audio and video recordings as needed for the purpose of treatment, payment or healthcare operations. I authorize the disposal of any tissues removed in the performance of any procedure. I am aware that the practice of medicine and surgery is not an exact science; that it involves my informed acceptance of certain risks versus benefits and I acknowledge that no guarantees have been made to me as a result of my examination and/or treatments.

COMMUNICATIONS REGARDING MY ACCOUNT: I agree that Cornerstone Clinic for Women, any other collection or servicing agency, or agencies retained by Cornerstone Clinic for Women (together referred to hereafter as “collectors”) to collect any money that I owe to Cornerstone Clinic for Women may contact me by telephone or text message at any number associated with my personal demographic information. I understand that this contact includes but is not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages.

COMMUNICATIONS REGARDING MY CARE: I agree that Cornerstone Clinic for Women may contact me by telephone or text message at any number associated with my personal demographic information for the purpose of care coordination, quality improvement activities, appointment reminders, wellness campaign reminders and insurance coverage/network status. I understand that this contact includes but is not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that Cornerstone Clinic for Women may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages.

RELEASE OF INFORMATION AGREEMENT: I understand Cornerstone Clinic for Women will generate, receive and store protected health information regarding my diagnosis and /or treatment. This information could include mental illness information, use of drugs and alcohol, or communicable diseases such as HIV/AIDS. I understand that the Notice of Privacy Practices provides information about how Cornerstone Clinic for Women and its workforce may use and/or disclose my information for the purposes of treatment, payment, healthcare operations and otherwise required by law. I hereby authorize Cornerstone Clinic for Women, in its discretion, to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of my charges or who may be responsible for determining the necessity, appropriateness, amount, or other

matter related to treatment or charges, including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, and the Social Security Administration or its intermediaries or carriers. I further authorize Cornerstone Clinic for Women, in its discretion, to disclose such information to its insurance carrier or carriers when so requested by such carrier and to my employer when said employer is actually liable for such charges.

INSURANCE COVERAGE: Your insurance coverage is a contract between you and your insurance company. We are not a party to that contract. If you have insurance, we will help you receive maximum benefits. If we accept your insurance, you must pay any co-payment and/or estimated coinsurance and deductibles prior to seeing the provider. In the event we accept assignment of benefits, the patient is still ultimately responsible for all charges.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for patients and we charge what is usual and customary for our area. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, etc., other than to provide factual information as necessary. You are responsible for the timely payment of your account.

NON PAYMENT: If your account is over 90 days past due, you will receive a letter that you have 30 days to pay your account in full. If the balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this clinic.

MISSED APPOINTMENTS AND PAPERWORK COMPLETION: The clinic will be charging a nominal fee for the completion of paperwork outside a scheduled visit. Additionally, the clinic will be charging $30 for appointments that are not kept or canceled with less than 24 hour notice. This policy will apply once you have missed or canceled with less than 24 hour notice the second appointment with this clinic. For in-office procedures (procedures, ultrasounds, mammograms, urologic, and hormone consults), cancellations must be made with at least a 48 hour notice from the time of the appointment or you will be charged a $45 fee.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign any and all rights and benefits to which I may be entitled arising out of any healthcare or liability insurance policy, Medicare or Medicaid to Cornerstone Clinic for Women. I authorize the full and undiscounted pursuit of payment on my account from any available liability insurance policy or third party source before submission of my account for payment to my own health insurance company or to Medicare or Medicaid. I hold Cornerstone Clinic for Women harmless of any reduction in healthcare benefits by my insurance company resulting from noncompliance with any clause or condition contained in my policy which may require: Notification; Precertification; Prior to Retrospective Authorization; or Utilization Review of the medical services I receive. Assignment of Insurance benefits is valid and binding until final payment of the account is received.

FINANCIAL RESPONSIBILITY AND PAYMENT REQUEST: The undersigned, jointly and severally, in consideration for the services rendered to the above named patient, accepts financial responsibility and agrees to pay in advance any applicable deductibles, copayments, coinsurance and estimated self-pay

dollars and to pay in arrears the clinic's rates and terms for services rendered to the patient upon receipt of a statement for such charges. The undersigned further agrees that if such indebtedness is

placed in the hands of a collector or an attorney for collection, the undersigned will pay reasonable attorney fees, interest, court costs and other collection costs and expenses. I also understand that I may qualify for financial assistance programs and that I may secure a determination of such upon request. I further understand that such a determination is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my qualification for financial assistance. I request that payment of authorized benefits be made on my behalf. I assign payment for unpaid charges for certain physician services furnished by specialists, and physicians for whom Cornerstone Clinic for Women is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance. I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I agree that I am financially responsible for deductibles and co-insurance not covered by my insurance.

Date: _____

Patient Name (Printed): _____

Patient Signature: _____