Kimberly Priebe, MD
Christian Garcia, MD
Mareca Pallister, MD
Megan Palmer, MD
M. Brie Todd, MD
Jeunesse Fredrickson, MD
Jennifer Berarducci, DO
Rachel Morr, PA-C
Aimee Birgenheier, WHCNP-BC
Sara Whitehead, PA-C
Lauren Melancon, FNP

FOUR CORNERS OB-GYN WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, NOTICE OF ELECTRONIC HEALTH INFORMATION EXCHANGE NOTIFICATION, & NOTICE OF FINANCIAL RESPONSIBILITY

ELECTRONIC HEALTH INFORMATION EXCHANGE NOTIFICATION

Four Corners OB-GYN (FCOG) endorses, supports, and participates in Electronic Health Information Exchange (EHIE) to improve the quality of your health and healthcare experience. EHIE provides us with a way to share patients' clinical information electronically securely and efficiently with other physicians and health care providers that participate in the EHIE network. Using EHIE helps your health care providers to share information and provide you with better care more effectively. The EHIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the EHIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the FCOG EHIE, or cancel an opt-out choice, at any time.

I have been offered a copy of FCOG's Notice of Privacy Practice and understand that this practice participates in EHIE.

I hereby authorize the release of my medical records to any physician involved in my care, as well as any medical information necessary to process claims. I also authorize the notification of test results, reminders, and other messages regarding my care to be left by mail, courier, e-mail, and/or voicemail.

FINANCIAL RESPONSIBILITY & RELEASE OF BILLING INFORMATION

I agree to be financially responsible for costs incurred for my care. I understand that, as a courtesy, FCOG will bill my insurance and that this does not transfer my financial obligation for services rendered to FCOG. **Please read the following carefully, then sign where indicated to acknowledge your understanding and acceptance. If you are a minor (under 18), your parent or legal guardian must accept financial responsibility on your behalf.**

1. I understand and accept I am financially responsible for all services provided to me by FCOG. I understand and agree to pay for all services provided to me by FCOG *at the time of service* unless my services are covered by a contracted insurance.

2. I understand and accept that I am responsible for the verification of my insurance coverage and benefit level for services rendered by FCOG providers and providers to whom I am referred by FCOG.

3. I understand and accept that my insurance company or health plan may require me to pay co-payments, co-insurance, or deductibles. If I have a co-pay, I agree to pay in full *at the time of service*. **Co-Payments are collected upon check in.** I agree to pay any co-insurance or deductibles *within 30 days* of my first statement from FCOG.

4. I understand and accept that I will be assessed a $40.00 fee plus any additional charges allowed by CRS 13-21-109 for any returned check.

5. I understand and accept that I will be charged a fee of $40.00 if I fail to keep my scheduled appointment(s) or fail to cancel my scheduled appointment(s) within 24 hours.

6. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to FCOG for any services furnished me by the physicians and practitioners in the office. I understand and accept that if, ***90 days*** after billing, my insurance has not paid, my account will be due and I will be responsible for payment in full of any outstanding balance.

7. I understand and accept that if my account becomes past due and/or is sent to collections, I will be responsible for all collection costs, attorney fees, court costs and any other miscellaneous fees. I consent to have the collection agency obtain my credit report for the purposes of collection on my account. **I also understand my account at FCOG will be locked, and no appointment(s) will be made until my debt is paid in full.**

8. I understand and accept that if further action must be taken on my account, I may be discharged from this practice and FCOG may require me to permanently seek further care elsewhere, in accordance with guidelines set forth by the Colorado State Board of Medical Examiners.

9. I understand and accept that specimens obtained in our office will be sent to outside laboratories for testing. I understand that there will be other outside services including but not limited to labs, pathology and diagnostic imaging that will be **billed separately**. Any questions regarding bills for laboratory, pathology and diagnostic imaging should be directed to the testing facility.

CONSENT FOR PURPOSES OF TREATMENT & ASSIGNMENT OF BENEFITS

1. I hereby consent and authorize FCOG to diagnose and treat me based on their professional, medical opinion. I have the right to revoke this consent, in writing, at any time, except to the extent that the practice has acted in reliance on this consent.

2. I consent to the use or disclosure of my protected health information by the medical providers at FCOG for diagnosing or providing treatment to me, obtaining payment from insurance companies or to conduct health care operations of the practice.

3. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of FCOG.

4. My "protected health information" means health information, including my demographic information, collected from me, and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

5. I hereby authorize and assign all payment and/or insurance benefits for medical services and/or surgical procedures to FCOG. I understand that I am responsible for all charges not covered by my insurance plan.

My signature below indicates that I have read and understand all the information above, and a copy is available to me upon request.

PATIENT NAME (PRINTED) _____ **DATE OF BIRTH:** ___/___/___

PATIENT'S SIGNATURE: _____ **DATE:** ___/___/___

GUARDIAN'S SIGNATURE: _____ **DATE:** ___/___/___