

DOCTOR: CHANG

¹Patient Registration Form & Financial Policy

First Name _____	MI _____	Last Name _____
Birth Date _____	SS# _____	Marital Status _____
Street Address _____	Apt # _____	
City _____	State _____	Zip Code _____
Home Phone _____	Work Phone _____	Ext _____ Cell phone _____
Employer _____	Occupation _____	
Insurance Carrier _____	Plan Type: _____	Policy Holder _____
Relationship _____	Policy # _____	Group # _____
Secondary Insurance Information _____		
Emergency Contact Name & Phone #: _____		

Insurance Billing Policy

Patient with active health insurance coverage through a carrier with whom this practice contracts must have their benefits verified before each visit. Third-party billing is offered with the following conditions:

- 1) Full estimated co-payment, co-insurance, and any unmet deductible are due at the time of service according to posted payment policies. The estimated co-payment, co-insurance, or unmet deductible may not be the actual charge once the claim has been processed by the insurance carrier. Patients may receive a refund for over-payment or a balance bill.**
- 2) Patients must provide insurance card and photo identification at each visit.**
- 3) Patients are fully responsible for obtaining any necessary referral before the appointment time.**

Although the practice staff makes every effort to obtain accurate information from the insurance carrier, verification of benefits is not a guarantee that an insurance carrier will fully or partially pay a claim. The insurance carrier makes the payment determination, based upon the plan's level of coverage and associated policies, upon receiving the claim.

I hereby request the direct payment of medical benefits be made to David M. O'Neil, M.D. and Gynemed Surgical Center (which are two separate entities) for any services rendered to me. I authorize any holder of medical information about me to release this information to my insurance carrier or its intermediaries, to the Health Care Financing Administration and its agents, to my attorney, or to another physician's office.

I understand that because these services are performed for me, I am financially responsible for all charges whether or not paid by my insurance carrier. If payment is fully or partially denied, I understand that my insurance carrier expects the practice to bill me directly for services rendered, and I agree to be personally and fully responsible for payment. If I fail to pay the balance of my account in a timely manner, I understand that my account may be turned over to a collections agency. I agree to pay all costs associated with this action including collection fees, attorney fees, and court costs.

Patient Signature: _____ Date: _____

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Gynemed Surgical Center Schedule of Common

CPT Code	Description	Charge	Charge	CPT Code	Description
99203	Office Visit	95.00	59840	Surgical D & C	500.00
76830	Sonogram, TV	90.00	56302		
36415	Venipuncture	25.00	-----	Facility Fee	850.00
86901	Rh Typing	15.00	99212	Follow-Up Visit	45.00
90782/J2790	RhoGam injection	140.00			

The actual amount paid by an insurance carrier will be based upon the plan's coverage level and contracted fee schedule. Please refer to your Explanation of Benefits (E.O.B.) for payment information.

INFORMATION FOR SELF-PAY PATIENTS

In order to make our services accessible to patients lacking health insurance coverage, our practice offers a significant discount for self-pay patients. We offer our surgical abortion service at a discounted package price that includes transvaginal sonogram, blood testing and RhoGam injection for Rh negative patients, surgical procedure with IV sedation, antibiotics, and birth control pills if appropriate. Patients are assumed to have had a positive pregnancy test before their appointment for surgical abortion. Patients are responsible for calling Gynemed to schedule their follow-up appointment for approximately two weeks after their procedure.

Medical abortion for those less than 8 weeks LMP \$400.00
Follow-Up Visit (within 10 days) 45.00

*** Note: Patients with health insurance coverage will never pay more than the discounted package price, regardless of liability indicated by their insurance carrier.**

In the event the procedure is not performed for whatever reason or circumstance, patients will be charged for any of the following services that are performed.

Transvaginal sonogram \$90.00 Physician Exam / Consult \$75.00
Abdominal sonogram \$90.00
Blood draw / testing \$25.00 Urine pregnancy test \$10.00
Staff Consultation \$30.00 Serum pregnancy test \$25.00

Note: Any laboratory work performed outside of Gynemed Surgical Center (including, but not limited to HCG quantitative pregnancy tests) will be billed by the outside laboratory. Gynemed Surgical Center has no involvement with laboratory billing.

There will be an additional \$120.00 charge for patients requiring a second sonogram at a later visit.

Self-pay patients who later wish to submit a claim to their insurance carrier should contact Gynemed Surgical Center which will submit the claim on the patient's behalf based upon the regular fee schedule. The patient will receive the appropriate refund if and when the practice receives reimbursement from the insurance carrier.

Patient Signature: _____ Date: _____

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HEALTH HISTORY

***Your medical records are strictly confidential and will not be released without your written consent.
Your complete and honest health history is necessary to provide you with the best medical care.***

GENERAL HEALTH HISTORY

Do you have any medical allergies? NO YES _____

Have you ever had a reaction to anesthesia? NO YES _____

Are you currently under medical treatment? NO YES _____

Do you take any medications/drugs regularly? NO YES When did you last take it? _____

Are you taking methadone? NO YES _____

Have you taken any prescription or street drugs today/recently? NO YES _____

Do you smoke? NO YES How many cigarettes per day? _____ For how many years? _____

Do you consume alcohol? NO YES How many drinks per week? _____

Please CIRCLE if you have ever, in the past or present, had any of the following:

- | | |
|-----------------------------|-------------------------|
| Anemia | Heart Murmur |
| Asthma / Hay fever | Hepatitis / Jaundice |
| Bladder / Kidney Infections | High Blood Pressure |
| Bleeding Problems | Hospitalization |
| Blood Transfusion | Rheumatic Fever |
| Blood Clots / Phlebitis | Sickle Cell Disease |
| Cancer | Shortness of Breath |
| Chest Pain | Stomach Pain / Ulcers |
| Diabetes | Swollen Feet / Ankles |
| Epilepsy / Seizures | SURGERY |
| Emotional Problems | HIV/AIDS |
| Gall Bladder / Appendicitis | Fainting / Dizzy Spells |
| Frequent Headaches | Drug Abuse/ Addiction |

Do you have any other health conditions of which we should be aware? NO YES

If so what? _____

Gynemed Surgical Center

NAME: _____ DATE: _____

When you choose to end a pregnancy at Gynemed Surgical Center, we consider both you physical and emotional health. Your responses to these questions help us provide you with the best possible care. We reserve the right to postpone or refuse our services to patients not deemed prepared for the abortion.

1) Please circle all words that describe how you feel:

Happy Sad Angry confident Guilty Scared

Confused Relieved Selfish Trapped Other _____

2) Are you sure of your decision to end this pregnancy?

3) What are the main reasons you have chosen to end this pregnancy?

4) Was this an easy or a difficult decision for you to make?

5) Have you discussed this decision with anyone? Have they been supportive?

Please check off the following items which concern you most today:

- ___ Not sure of your decision to have an abortion
- ___ Is this going to hurt?
- ___ Is this confidential?
- ___ Your relationship with your partner
- ___ Your relationship with your family
- ___ Will this affect future pregnancies?
- ___ Possible complications
- ___ Your religious beliefs or teachings
- ___ How you will feel after the procedure

In accordance with Maryland state law, I have received a list of agencies which could offer me assistance if I wanted to maintain my pregnancy.

Patient Signature: _____ Date _____

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**ADDITIONAL INFORMATION REGARDING THE TREATMENT OF EARLY PREGNANCY WITH
MIFEPRISTONE**

Enclosed in this packet is additional information from the U.S Food and Drug Administration website regarding the use of Mifepristone for the termination of early pregnancy.

I, _____, have read and understood the FDA advisory regarding deaths associated with the medical abortion.

The FDA and the Provider of the Mifepristone have recommended 600 mg (#3 200 mg tablets) to be used for the termination of early pregnancy.

Since then, there have been sufficient studies that have proven that 200 mg of Mifepristone (#1 200 mg tablet) is just as effective as #3 tablets.

This will cut down on the cost of the procedure and the possible side effects associated with the medication. We recommend only #1 tablet (200 mg).

I, _____, accept the modification of the dosage of Mifepristone as recommended above by Gynemed Surgical Center.

Patient Signature: _____

Date: _____

**INFORMED CONSENT TO VOLUNTARY
MEDICAL ABORTION & RELATED SERVICES**

Initials

I, _____, am ____ years old, and was born on _____. I hereby request and consent to have Gynemed Surgical Center provide me with medication to terminate my pregnancy. I fully understand the purpose of this medicine is to terminate my pregnancy. This is my personal decision, and no one has coerced me or compelled me to make this decision.

*I am under eighteen years of age.
I understand that if I require emergency hospital treatment, my parent(s) or legal guardian may be contacted.*

Name of parent / legal guardian: _____

Street Address: _____ *City / State:* _____

Telephone Number: _____

Gynemed Surgical center encourages young women to discuss their pregnancy and options with a parent, relative or trusted adult. Under 1992 state law, the parent(s) of women under age 18 must be notified before an abortion is performed, unless specific conditions exist (see below).

- Parent has accompanied their minor daughter to Gynemed Surgical Center and acknowledges minor's abortion decision.

Parental Acknowledgement: I hereby acknowledge that I am fully aware that my daughter has requested an abortion and that the physician intends to perform an abortion.

Signature of parent / legal guardian:

- In Accordance with Maryland State Law, minor's **parent has not been notified** of patient's intention to have an abortion because:

- The minor is mature and capable of giving informed consent to an abortion
- Notification would not be in best interest of minor
- Notice may lead to physical or mental abuse of minor
- Minor patient does not live with parent or guardian

Minor Patient's Signature _____

Witness Signature _____

Physician's Signature _____

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_____ I have completely and accurately disclosed my medical history, including any health conditions, sexually transmitted infections, known allergies, and medications or drugs taken within the last forty-eight hours. I authorize the physician to make medical decisions based upon these disclosures. The medical allergies I have listed are: _____

_____ I consent to the taking and testing of blood samples if necessary. I understand these tests are routinely performed and are a necessary component of my care.

_____ I also understand that I can choose a surgical abortion as an alternative to a medical abortion. I choose a medical abortion.

_____ I consent to the administration of Misoprostol (Cytotec) and Mifepristone (RU486). I understand that these medications cause cramping, nausea, vomiting and /or vaginal bleeding. I understand that these medications can cause birth defects, if I fail to go through with the abortion; I assume full responsibility for this.

_____ I have read and understand the discharge instructions and a copy has been provided to me.

_____ I consent to the exchange of medical records between Gynemed Surgical Center and any other provider, physician, hospital, or clinic pertaining to my medical treatment.

_____ **I understand that complications which May Occur After the Medical Abortion include the following:**

- a. **Post-Abortion Syndrome**, trapped blood clots in the uterus which may cause severe cramping and abdominal pain. A surgical procedure may be required.
- b. **Incomplete abortion**, tissue left inside the uterus which may cause bleeding or infection. A surgical procedure may be required.
- c. **Continuing pregnancy** due to failure of the treatment which occurs in about 5 to 8 out of 100 women who use this treatment. Continuing pregnancy may also be due to multiple pregnancies, double uteri, or ectopic pregnancy. A surgical procedure would be required, and an ectopic pregnancy may require hospitalization and treatment.
- d. **Infection of the uterus, with or without infection of the fallopian tubes and ovaries**, which may require hospitalization antibiotic therapy and very rarely can lead to the loss of childbearing capacity or death.
- e. **Hemorrhage** / heavy bleeding which may require evaluation and/or hospitalization of the patient and further treatment.
- f. **Emotional problems**. Although most women report relief, some women may experience depression or guilt following an abortion. Our staff is available to help women deal with these feelings or provide appropriate referrals.

In the event of an emergency, I authorize the physician at Gynemed Surgical Center to provide emergency care using his / her medical judgment, including transfer to a local hospital. I understand that patient confidentiality can not be preserved if transfer to a hospital is necessary.

In the event of an emergency, I authorize Gynemed Surgical Center to contact the following individual:

Name: _____ Relationship: _____

Street Address: _____ City / State: _____

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Telephone Number: _____

I understand that I would be financially responsible for any expenses arising from complications from the abortion procedure. I understand such complications can be caused by my own condition or conduct and through no fault of the physician.

I have received written discharge instructions, and I understand the importance of follow-up care. I agree to call Gynemed Surgical Center regarding any questions or complications I may have.

I understand Gynemed Surgical Center has the right to refuse me services for whatever reason they deem appropriate.

I have read and understand the above information including PATIENT RIGHTS AND REPONSIBILITIES. I understand the above risks and accept these risks. I consent and have decided to take Mifeprex and Misoprostol to end my pregnancy.

Patient Signature: _____ Date: _____

Signature of Gynemed Surgical Center Witness: _____

**COMBINED HORMONAL CONTRACEPTIVE METHODS (CHCM)
CONSENT FORM**

This fact sheet explains the good things and the possible problems of CHCM. If you do not understand all the information, or if you have any questions, please ask your clinician/counselor.

What is it? CHCM include the birth control pill, the birth control vaginal ring, and the birth control patch. They are safe and effective methods of birth control. They are methods which must be used correctly and consistently. You should choose one of these methods of birth control only after reading this fact sheet and discussing your birth control needs with a counselor.

How do CHCM prevent pregnancy?

Each of your ovaries contains thousands of unripe eggs. About half way between the start of one period and the start of the next period, an egg ripens and is released into the tube of the uterus. This is called ovulation. CHCM prevent this from happening. The hormones also thicken your cervical mucus so sperm are not able to swim through it.

Who may take CHCM? Most women can safely use these methods throughout their reproductive years as long as they do not have specific medical problems which would create a health risk.

Who should not take CHCM?

You should not use these methods if:

- you are or suspect you may be pregnant
- you have abnormal vaginal bleeding that has not yet been evaluated
- you presently have serious liver disease
- you have ever had any kind of growth in the liver
- you are being treated for or have a history of cancer in the breast
- you have a lump in the breast that has not yet been evaluated
- you are being treated for or have a history of any estrogen-dependent cancer
- you are being treated for blood clots in the body or have a history of ever having a blood clot/hypercoagulability (Known thrombogenic mutations (e.g. Factor V Leiden, Prothrombin mutation, Lupus Anticoagulant, Protein C, Protein S and Antithrombin deficiencies)
- you have ever had a stroke

- you are 35 years of age or older and you smoke cigarettes
- migraine with aura or neurological change

If you now have or have had a health problem such as migraine headaches, heart disease, high blood pressure, diabetes or gallbladder disease, or are a heavy cigarette smoker, tell your clinician so that she or he may decide if it is safe for you to take these methods. Each of these problems can be made worse by the use of CHCM.

It is known that if a woman smokes cigarettes while using CHCM, she is at higher risk of medical problems. Therefore, women who use these methods are advised not to smoke.

COMMON PROBLEMS

CHCM can have side effects in some women. Fortunately, the side effects are usually not serious. While taking these methods the following problems could occur:

MINOR PROBLEMS

- nausea
- spotting between periods
- less menstrual bleeding
- breast tenderness
- weight gain
- headaches
- depression
- high blood pressure
- darkening of the skin or face
- worsening of acne
- hair loss or increase in hair growth
- decreased sex drive

MAJOR PROBLEMS

- blood clots of the leg or lung (risk is less than that of being pregnant)
- stroke or heart attack
- liver tumors
- gallbladder disease

How effective are CHCM? If CHCM are used perfectly (as directed and other instructions are followed), only about 1 in 1,000 women may become pregnant within the first year. CHCM are

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only effective while you are taking them. As soon as you stop taking these methods you are no longer

protected from pregnancy

CHCM while breast feeding if other options are available.

BENEFITS

Many women experience the following benefits from using these methods:

- decreased menstrual cramps
- decreased menstrual bleeding
- more regular menstrual bleeding
- decreased pain at the time of ovulation
- improvement in acne
- less risk of developing ovarian and/or endometrial cancer
- less risk of developing benign breast tumor and/or ovarian cysts
- some women note a reduction in PMS

- Lack of protection against STDs. While CHCM are a highly-effective, convenient methods of birth control, they do not provide any protection against sexually transmitted infections such as gonorrhea, chlamydia, or HIV (the virus that causes AIDS). If you or any of your sexual partners have other partners, it is very important to use a latex condom every time you have sex in order to protect yourself against these infections.

PRECAUTIONS YOU SHOULD TAKE

Tell any health care provider that you see that you are using CHCM.

REPORT ANY NEW OR UNUSUAL MEDICAL PROBLEMS TO YOUR CLINICIAN RIGHT AWAY

Other medical drawbacks and risks:

- Between 1% and 2% of women will not menstruate for 6 months or more after stopping CHCM. If you do not have your period, return to the clinic for a pregnancy test.
- If your periods are irregular prior to taking pills, they may again become irregular after you stop these methods.
- The estrogen hormone in these methods slightly decreases the quality and quantity of breast milk. Some experts advise against

When using these methods, you should call your clinic right away if you have any of the following:

- numbness or severe headaches which are not tension headaches and are not relieved with aspirin
- severe leg pain (calf or thigh; usually one leg)
- severe chest pains, shortness of breath eye problems; blurred vision, flashing lights, or blindness
- severe abdominal pain

Please read each of the listed items below and place a check in the box provided that applies to you.

- I understand the side effects, risks, and benefits in using combined hormonal contraceptives. I have also been explained other alternative methods of birth control.
- I have read the above statement about Combined Hormonal Contraceptive Methods and have had the opportunity to ask questions.
- I wish to receive a combined hormonal contraceptive method.

Complete the spaces below.

Patient: Date _____

Name (please print) _____ Signature _____

Witness: I was present when this form was orally explained, in detail, to this client. To the best of my knowledge and belief, this client understands the information contained in this form. If the client is a minor, I have assessed the client's conduct and sexual relationships and I believe the client to be a mature minor.

Date _____

Name _____ Signature _____

Mifeprex (mifepristone) Information

Mifeprex is used, together with another medication called misoprostol, to end an early pregnancy (within 49 days of the start of a woman's last menstrual period). Since its approval in September 2000, the Food and Drug Administration has received reports of serious adverse events, including several deaths, in the United States following medical abortion with mifepristone and misoprostol. Each time FDA receives a report of a serious adverse event or death after medical abortion with these drugs, the agency carefully analyzes the available scientific information to determine whether or not the serious adverse event or death is related to the use of the drugs.

As previously reported by the agency, several of the women who died in the United States died from sepsis (severe illness caused by infection of the bloodstream) after medical abortion with mifepristone and misoprostol. Sepsis is a known risk related to any type of abortion. Most of these women were infected with the same type of bacteria, known as *Clostridium sordellii*. The symptoms in these cases of infection were not the usual symptoms of sepsis. We do not know whether using mifepristone and misoprostol caused these deaths.

Patients should contact a healthcare practitioner right away if they have taken these medications for medical abortion and develop stomach pain or discomfort, or have weakness, nausea, vomiting or diarrhea with or without fever, more than 24 hours after taking the misoprostol. These symptoms, even without a fever, may indicate sepsis. Patients should make sure their healthcare practitioner knows they are undergoing a medical abortion.

All providers of medical abortion and emergency room healthcare practitioners should investigate the possibility of sepsis in women who are undergoing medical abortion and present with nausea, vomiting, or diarrhea and weakness with or without abdominal pain. These symptoms even without a fever may indicate a hidden infection. Strong consideration should be given to obtaining a complete blood count in these patients. Significant leukocytosis with a marked left shift and hemoconcentration may be indicative of sepsis.

FDA recommends that healthcare practitioners have a high index of suspicion for serious infection and sepsis in patients with this presentation and consider immediately initiating treatment with antibiotics that includes coverage of anaerobic bacteria such as *Clostridium sordellii*.

FDA does not have sufficient information to recommend the use of prophylactic antibiotics for women having a medical abortion. Reports of fatal sepsis in women undergoing medical abortion are very rare (approximately 1 in 100,000). Prophylactic antibiotic use carries its own risk of serious adverse events such as severe or fatal allergic reactions. Also, prophylactic use of antibiotics can stimulate the growth of "superbugs," bacteria resistant to everyday antibiotics. Finally, it is not known which antibiotic and regimen (what dose and for how long) will be effective in cases such as the ones that have occurred.

These recommendations are consistent with warnings in the Prescribing Information and information for the patient in the Medication Guide for Mifeprex.

The approved Mifeprex regimen for a medical abortion through 49 day's pregnancy is:

- Day One: Mifeprex Administration: 3 tablets of 200 mg of Mifeprex orally at once
- Day Three: Misoprostol Administration: 2 tablets of 200 mcg of misoprostol orally at once
- Day 14: Post-Treatment: The patient must return to confirm that a complete termination has occurred. If not, surgical termination is recommended to manage medical abortion treatment failures.

The safety and effectiveness of other Mifeprex dosing regimens, including use of oral misoprostol tablets intravaginally, has not been established by the FDA.

On May 11, 2006, FDA, in conjunction with the Centers for Disease Control and Prevention (CDC) and the National Institute of Allergy and Infectious Diseases (NIAID), conducted a public workshop. This workshop, entitled "Emerging Clostridial Disease," discussed the scientific and medical circumstances associated with reports of morbidity and mortality with *Clostridium sordellii* and *Clostridium difficile* infections.

- [Questions and Answers](#) (issued 8/29/2007)
- [Mifeprex Label \[PDF\]](#) (approved 7/19/2005)
 - [Medication Guide \[PDF\]](#)
 - [Patient Agreement \[PDF\]](#)

Historical Information

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Do Not Buy Mifeprex Over the Internet

- You should not buy Mifeprex over the Internet because you will bypass important safeguards designed to protect your health (and the health of others).
- Mifeprex has special safety restrictions on how it is distributed to the public. Also, drugs purchased from foreign Internet sources are not the FDA-approved versions of the drugs, and they are not subject to FDA-regulated manufacturing controls or FDA inspection of manufacturing facilities.

To learn more about buying drugs safely, please see

- [Buying Prescription Medicines Online: A Consumer Safety Guide.](#)

Updated: 6/26/2009

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**GYNEMED SURGICAL CENTER PATIENT FOLLOW-UP
INFORMATION FORM**

The purpose of this form is to help us keep track of our patients after their procedure here in our office. Please provide the information listed below so that we may contact you in the coming days regarding your recovery. If you visit the hospital for any reason regarding your procedure, please inform our staff when they call so we may update our records (we may request copies of your hospital report). In the event you visit the hospital after we have the chance to talk with you, we would appreciate it if you still called and notified our office. If you have any questions please talk to any one of our staff. Thank you.

First Name: _____ Last Name: _____

Date of Procedure: _____

Date of Birth: _____

Are you having a surgical or medical (“Termination Pill”) procedure? Surgical Medical

Last four Social Security numbers (for security and patient verification purposes): _____

Phone number where you can be reached: (_____) _____

Is it okay to leave a message if needed? Yes No

Although adverse incidents are rare following an abortion procedure, it is our goal to follow up with you personally to make sure that all of your healthcare needs are met. To ensure your health and safety, it is **VERY IMPORTANT** to schedule a follow up appointment as soon as possible if you have not already done so. Thank you very much for choosing ***Gynemed Surgical Center*** for your healthcare needs. We understand the importance and need for quality women’s health care and strive to provide you with just that and more.

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FOR ADMINISTRATIVE PURPOSES ONLY

Call Date: _____ Staff Initials: _____

Patient Reached? Yes No If no, was a message left? Yes No

If medical, was the pregnancy passed? Yes No N/A

Did the patient experience fevers over 100.4F? Yes No

Did the patient have any excessive bleeding that soaked more than two pads per hour? Yes No

Did the patient experience excessive pain that could not be eased with Tylenol or Ibuprofen? Yes No

Did the patient go to the hospital for any reason? Yes No

If yes, where and when? _____

Any other issues following the procedure?

Do you have a follow-up scheduled? Yes No

If no, would you like to schedule one? Yes No

Staff Signature: _____

Gynemed Surgical Center - Patient Easy-Pay Consent

In the event a balance is owed after your claim has been submitted to your insurance company, the Easy-Pay system allows for a convenient and safe way to pay off the balance without the hassle of monthly balance reminders and collection notices which can affect your credit. PLEASE NOTE, your card will only be charged in the event your claim is unpaid and will never exceed the Self-Pay price(s) as listed below.

I, _____, authorize Gynemed Surgical Center, to charge my credit card for the balance of charges not paid by my private insurance or medical assistance.

Self-Pay Discounted Price List

Paragard IUD (w/insertion): \$450.00
Mirena IUD (w/insertion): \$550.00
Implanon (w/insertion) \$700.00

Medical Procedure (by pill): \$400.00

Surgical Procedure:

5-14.6 Weeks: \$400.00
15-16 Weeks: \$800.00
16.1-17 Weeks: \$950.00
17.1-18 Weeks: \$1,150.00
18.1-19 Weeks: \$1,600.00
19.1-20 Weeks: \$1,800.00
20.1-21 Weeks: \$2,000.00
21.1-22 Weeks: \$2,200.00

*Surgical procedure discounted prices include sedation, sonograms, antibiotics, and lab tests.

Patient Name:			
Card Holder's Name (if different from patient's):			
Card Holder's Address:			
City:		State:	Zip Code:
Debit/Credit Card Number: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover <input type="checkbox"/> American Express			Expiration Date:

Cardholder Signature: _____ Date: _____

***PLEASE NOTE: this form will remain in the patient's chart until its proper destruction and is protected by the rules and regulations of HIPPA. This form WILL NOT be used and/or shared with anyone outside of Gynemed Surgical Center.**

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Consent for Purposes of Treatment, Payment, and Healthcare Operations

Gynemed Surgical Center

Although this form is no longer required for HIPPA compliance, you are being asked to sign this form because it is either required for state or other compliance. If you have any questions about this form please contact our present Office Manager.

CONSENT

I consent to the use of disclosure of my protected health information by Gynemed Surgical Center for the purpose of diagnosing me or providing treatment to me, for obtaining payment for my healthcare bills, or to conduct the healthcare operations of this organization. I understand that diagnosis or treatment of my by my physician may depend upon my consent as evidence by my signature on this document.

RESTRICTION ON THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION

I understand that I have the right to request that this organization restrict the way my protected health information is used or disclosed in order to treat me to obtain payment or for the other healthcare operations of the organization. The organization is not required to agree to the restrictions that I may request, but if the organization does agree to a restriction that I request, the restriction is binding on the organization and on the staff.

REVOKE CONSENT

I have the right to revoke this consent, in writing, at any time, except to the extent that my physician or this organization already has taken action based upon this consent.

DEFINITION OF PROTECTED HEALTH INFORMATION

My “protected health information” means health information, including my demographic information such as but not limited to age, my occupation, and the address at which I live, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, a healthcare clearinghouse, or any other entity that uses or creates health information about and that has a business relationship with this organization. This protected health information relates to my past, present, or future physical or mental health or condition and either identified me, or there is a reasonable basis to believe that the information might identify me. It does not include certain education records covered by the Family Education Rights and Privacy Act and records held by a covered entity in its role as an employer those exclusions may not apply to you as a patient of this practice.

RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES

I understand that I have the right to review this organization’s Notice of Privacy Practices before I sign this consent document. That document has been provided to me. The Notice of Privacy Practices describes the way my protected health information will be used or disclosed during my treatment, during the payment of my bills, or during the performance of the health care operations of this organization. The Notice of Privacy Practices for this organization is provided in the Waiting Are. This Notice of Privacy Practices also describes my rights and this organization’s duties with respect to my protected health information.

Gynemed Surgical Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices by accessing the organization’s website, calling or faxing the office and requesting that a revised copy be sent to me in the main, or by asking for a revised notice at the time of my next appointment.

Signature of Patient or Personal Representative:

Date: