

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	CPT Code	Description	Charge
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.

Up to 12.0 weeks LMP	\$400.00	(As measured by transvaginal sonogram at Gynemed on date of procedure)
12.1 – 13.0 weeks LMP	\$400.00	
13.1 – 14.0 weeks LMP	\$400.00	
14.1 - 14.6 weeks LMP	\$400.00	
15.0 – 16.0 weeks LMP	\$800.00	
16.1 – 17.0 weeks LMP	\$950.00	
17.1 –18.0 weeks LMP	\$1,150.00	
18.1 – 19.0 weeks LMP	\$1,600.00	
19.1 – 20.0 weeks LMP	\$1,800.00	
20.1 – 21.0 weeks LMP	\$2,000.00	
21.1 – 22.0 weeks LMP	\$2,200.00	

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 _____

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? _____

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GYNECOLOGICAL HEALTH HISTORY

Age of First Period: _____ Are you periods regular? YES NO Days of Flow: _____

Cramps: None Mild Moderate Severe Relieved by: _____

First Day of Last Menstrual Period: _____ Normal? YES NO _____

Have you ever had an internal pelvic examination? YES NO

Last exam / Pap smear: _____ Findings: _____

Have you ever had an abnormal pap smear? NO YES When: _____ Treatment: _____

Please circle if you have ever had any of the following:

Breast Lump / Tumor

Herpes

Chlamydia (Date: _____) Treated? Y N Pelvic Inflammatory Disease

Gonorrhea (Date: _____) Treated? Y N Syphilis

Disease / Surgery of Female Organs Other: _____

PREGNANCY HISTORY

Number of previous pregnancies: _____ History of twin / multiple pregnancies: NO YES

Number of live Vaginal births: _____ Month/Years : _____

C-Sections? _____ Month/Years _____ Complications: _____

Number of stillbirths: _____ Month/Years: _____

Number of miscarriages: _____ Month/Years: _____ D&Cs? _____

Number of abortions: _____ Month/Years: _____ Any 12+ weeks? _____

Number of ectopic pregnancies: _____ Month/Years: _____ Rupture? _____

CONTRACEPTIVE HISTORY

Were you using contraception when you became pregnant this time? NO YES Type: _____

Have you ever used any of the following birth control methods?

_____ Birth Control Pills When: _____ Brand: _____ Side Effects _____

_____ Depo Provera / Norplant When: _____ Side Effects? _____

_____ Condoms _____ Foam/Barriers _____ Diaphragm _____ IUD

_____ Other: _____

What method of contraception do you plan to use in the future? _____

The patient's medical /surgical history reviewed by attending physician _____

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

Initials

_____, I, _____, am _____ years old, and was born on _____. I hereby request and consent to have Gynemed Surgical Center perform a surgical abortion on me. I fully understand the purpose of this procedure 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 understand that the products of conception will be removed during the abortion, and I consent to their disposal by Gynemed Surgical Center in a manner they deem appropriate.

_____ I consent to the administration of an anti-anxiety medication (Alprazolam) during my pre-operative care which is intended to help me relax before the procedure. Possible side effects may include drowsiness, impaired coordination, headache, and dry mouth. I understand that in a small number of women, severe reaction or shock may occur, requiring emergency care.

_____ I consent to the administration of Misoprostol (Cytotec), whose purpose is to soften and dilate my cervix to facilitate the abortion process. I understand that Misoprostol can cause cramping, nausea, vomiting, diarrhea, and /or vaginal bleeding. I understand that Misoprostol can cause birth defects, if I fail to go through with the abortion; I assume full responsibility for this.

_____ I also understand that if I am early in my pregnancy, I can choose a medical abortion as an alternative to a surgical uterine aspiration. I choose a surgical method for my abortion.

_____ Do you currently have a **Living Will** or **Advanced Directives** in place, **YES OR NO** Please be advised that Gynemed Surgical Center does **NOT HONOR LIVING WILLS**.

_____ *I consent to the administration of intravenous sedation which is intended to control pain, relax me during the procedure. I may experience drowsiness, fatigue, poor muscular coordination, partial amnesia, and possible phlebitis (vein inflammation) at the injection site. I understand that in a small number of women, severe reaction or shock may occur, requiring emergency care.*

_____ I understand that due to the medications I will receive during my visit to Gynemed Surgical Center, I must not drive myself home after my procedure nor engage in any activity requiring mental alertness for twenty-four hours. I have brought a driver with me, and he or she will be responsible for ensuring my safe return home.

Driver's Name: _____

Driver's Contact Number: _____

Driver's SIGNATURE: _____

_____ I understand that due to the medications I will receive, I must have an adult's supervision at least twelve hours after completion of my procedure. I have arranged for someone to be responsible for my safety and wellness at home.

Responsible Adults Name: _____ Contact Number: _____

_____ *I have failed to bring a driver to provide me a ride home. Therefore, I am arranging for a taxi to drive me home. I understand that I am not eligible to receive pre-operative medication or deep sedation. I have been given the option to reschedule my appointment but am choosing to proceed. I understand that the physician will use his/her medical judgment to determine which, if any, medications I may receive. I hereby release Gynemed Surgical Center for any and all liability and responsibility for my safe return home after receiving any medications.*

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_____ 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 with surgical abortion are uncommon but could include the following:**

- **Laceration (tearing) of the cervix**, which may require suturing.
- **Perforation or injury to the uterus**, which may include damage to internal organs, including bowel, bladder or blood vessels. Hospitalization would be required, and surgery may be necessary. Rarely, the loss of childbearing capacity may occur.
- **Hemorrhage**, heavy bleeding which may require evaluation of the patient and further treatment including blood transfusion and rarely require a hysterectomy (remove my uterus)
- **Reaction to anesthesia and/or medications** resulting in shock, convulsions, or death.

_____ **Other complications Which May Occur After the Procedure:**

- a. **Post-Abortion Syndrome**: trapped blood clots in the uterus which may cause severe cramping and abdominal pain. A second suction procedure may be required.
- b. **Incomplete abortion**, tissue left inside the uterus which may cause bleeding or infection. A second procedure may be required.
- c. **Continuing pregnancy** which may be due to multiple pregnancies, double uteri, or ectopic pregnancy. A second 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 antibiotic therapy and very rarely can lead to the loss of childbearing capacity.
- e. **Hemorrhage / heavy bleeding** which may require evaluation 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.
- g. **Cervical stenosis/scarring** – which may require re-dilation.
- h. **Formation of scar tissue in the uterus/infertility**.

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: _____

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.

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I understand that no guarantees about my future fertility can be offered to me, and no such guarantees have been made to me. I understand that there is evidence that women who have more than three induced abortions may be at increased risk for premature labor.

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 RESPONSIBILITIES. I understand the above risks and accept these risks. I consent and request that a surgical abortion be performed on me.

Patient Signature: _____ Date: _____

Translator Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Signature of Gynemed Surgical Center Witness: _____ Date: _____

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1. Please mark the concerns you have today:

- I don't understand how an abortion is done
- I'm wondering how I'll feel after
- I'm not sure of my decision
- I'm worried about how to avoid getting pregnant again
- I'm afraid people will find out / judge me
- I know I will regret the abortion
- I'm worried I won't be able to get pregnant when I want to
- Will this hurt?
- My relationship with my partner or family
- Possible complications during and after the abortion
- I don't have anyone to talk to about it
- Other: _____

2. Circle all the words that describe how you feel:

- | | | | | |
|--------|-------------|---------|-----------|---------------|
| Sad | Happy | Angry | Trapped | Confident |
| Lost | Nervous | Selfish | Helpless | Irresponsible |
| Mean | Comfortable | Worried | Nauseated | Disappointed |
| Scared | Powerful | Relaxed | Ashamed | Resolved |
| Hungry | Relieved | Numb | Guilty | |

3. What is the name of the person who came with you today? _____

4. Was this decision difficult or easy for you? _____

5. Whose decision is it for you to have this abortion? _____

6. Have you discussed this decision with anyone? If so, whom? _____

7. Does the man involved know about your decision? If so, is he supportive? _____

8. What are your thoughts about ending this pregnancy? _____

9. Have you had any difficult experiences with pregnancy in the past? _____

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You will fill this part out during individual counseling with your counselor:

The following information has been discussed with the patient

___ The patient has considered all her options: abortion, adoption, and giving birth

___ The patient has made her own decision to have an abortion and expresses confidence in that decision

___ We discussed the procedure, aftercare, and prescriptions

___ We have discussed birth control methods

I, _____, have been informed of all the information listed above.
Patient Signature

I, _____, have discussed the above information with the patient.
Counselor Signature

Counselor Notes: _____

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

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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

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

CHCM while breast feeding if other options are available.

- 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.

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 _____

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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: _____

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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: