ACKOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICE

I have been given a copy of the HIPPA Notice of Privacy Practice for Selah Women's Health _____
Initial

Under the Patient Privacy Act, also known as HIPPA, our office cannot release or discuss patient information with anyone other than the patient, legal guardian or custodial parent, unless we have written authorization from the patient.

You can choose to allow us to speak with family members or care givers regarding your healthcare by completing the following, indicating the person by full name, to whom we may speak.

I, _____, authorize Selah Women's Health to release and/or discuss my private health information with the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Entire Record _____ OR Specific Information Only _____

_____ I **do not** want any information released to anyone by Selah Women's Health, with the exception of the Physician who referred me to this practice.

This authorization will remain in effect until I have revoked this authorization in writing. My written revocation must be submitted in writing to:

Selah Women's Health
2216 Buenaventura Blvd Ste B
Redding, CA 96001

_____ _____
Signature Date

_____ _____
Print Patient Name Relationship (if not patient)

ASSIGNMENT OF INSURNACE BENEFITS

I hereby authorize direct payment of medical/surgical benefits to Selah Women's Health for services rendered. I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Selah Women's Health to release any medical or incidental information that may be necessary to secure the payment of benefits.

CONTACT INFORMATION AND INSURANCE CERTIFICATION

I certify that the information given by me in applying for payment is correct to the best of my knowledge. I authorize release of all records upon request. I request that payment of authorized benefits be made on my behalf. I further agree that a photocopy of these assignments shall be as valid as the original.
I agree to be responsible for any costs associated with the collection of funds owed to the practice, including but not limited to: collection agency fees, attorney fees and court costs. In the event the account becomes delinquent and is assigned to a collection agency, I hereby authorize Selah Women's Health and/or their agent to obtain a copy of my credit report from the national credit bureaus, including but not limited to: TransUnion, Equifax and Experian.

_____
Patient / Parent Guardian (Please Print)

_____
Signature

_____
Date

CASH / INSURANCE AGREEMENT

Upon signing below, I agree that I have no additional active health insurance policy under my name, nor any policy in which my name is included (for example, a family policy in which I am listed as a spouse or dependent).

I agree that if I an additional insurance policy is discovered under which my name is listed upon such document, Selah Women's Health may refuse to continue to offer me services at that point.

I understand that it is fraud for Selah Women's Health to collect cash from me if I have an additional health insurance policy that I am not disclosing. Therefore, it is of utmost importance that I am honest and upfront in stating any past, current or any change in my insurance coverage.

If I decide to take out an additional insurance policy while I am a patient at Selah Women's Health I will submit the policy and fully disclose my intentions to do so. I understand that by changing my current insurance status, there is a possibility that I will no longer be able to receive services from Selah Women's Health.

By signing below, I agree to the above guidelines.

_____

Patient / Parent Guardian (Please Print)

_____

Signature

_____

Date

PATIENT CANCELLATION AND NO-SHOW AGREEMENT

Effective January 1, 2018 SWH will enforce a new Cancellation and No Show Policy.

Our goal is to provide quality medical care in a timely manner. In order to achieve this, we have implemented a cancellation/no show policy. This policy allows SWH to better utilize available appointments for our patients in need of medical care.

For your convenience, our office will coordinate appointment reminders and send a **text** message 4 days prior to your scheduled appointment. This only pertains to those who have a cell phone listed with us. We will also **call** two days ahead to remind you of your appointment.

Cancellation of an appointment

In order to be respectful of the medical needs of other patients, please be courteous and call Selah Women's Health promptly if you are unable to attend an appointment. This time will be utilized for someone who is in need of medical care. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Patients who cancel appointments with **less than 24 hours' notice will be considered a No Show.** Appointments are in high demand and your early cancellation will give another patient the opportunity to be scheduled during this time.

How to cancel and reschedule your appointment

To cancel / reschedule appointments, please call (530) 338-0002. If you are unable to reach our patient care coordinator, you may leave a detailed message on the voicemail. A minimum of 24 hours cancellation notice is required for appointments. If you would like to reschedule your appointment, please be sure to leave your contact information and the best time to return your call.

No-Show policy

A "no-show" is someone who misses an appointment without cancelling in a timely manner. "No-Shows" inconvenience other patients who need access to medical care. You will receive a letter informing you of the No Show with a copy of this policy/agreement and a **$35 fee** assessment.

We realize that an emergency may occur, and you may not be able to notify us. This can be discussed if the situation arises.

Thank you for working with us to ensure that services are provided to all of our patients in the best possible way.

Acknowledgement of Cancellation & No Show Agreement

Signed: _____ Date Signed_____

Print Name: _____

If Patient is a Minor Print Name_____