Suburban Gynecology, LLC
HIPAA and Patient Signature Form

PLEASE INITIAL EACH SECTION & SIGN AT THE BOTTOM

***_____ HIPPA PRIVACY NOTICE AND OTHER PROVISIONS:**
I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices from the office staff and have been informed of my additional rights under HIPAA.

***_____ CONSENT TO TREAT:**
I hereby authorize and consent to the performance of examinations, diagnostic procedures, injections, and treatments, which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

***_____ AUTHORIZATION TO DISCUSS MY MEDICAL INFORMATION/ACCOUNT**
My medical condition, information and account may be discussed with the following persons:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

***_____ COMMUNICATION AGREEMENT:**
Preferred method of communication (circle one):
Mail / E-mail /Cell Phone/ Home phone

- ☐ Okay to mail to my home
- ☐ Okay to e-mail me at _____
- ☐ Okay to call me and/or leave a message regarding personal medical information at:
  - Home number
  - Cell number

***_____ RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:**
I understand that Suburban Gynecology, LLC will submit claims on my behalf to my insurance company; I hereby authorize Suburban Gynecology, LLC to furnish information to my insurance carrier concerning all conditions including those that may reference drug abuse, alcohol abuse, mental illness, or HIV status. I hereby assign to Suburban Gynecology, LLC payments made by my insurance carrier until such time as I revoke this in writing.

***_____ PATIENT FINANCIAL RESPOSIBILITY:**
I understand that as a courtesy to me, Suburban Gynecology, LLC will submit the charges for my visit to my primary and secondary insurance carriers. If there are any questions regarding coverage, benefits, or payments for services provided, I understand that it is my responsibility to resolve them. I also understand that I am financially responsible for all charges whether or not they are covered by my insurance carrier.

My signature in the box below indicates my knowledge of and agreement with the above. Furthermore, I understand and agree that my consents/assignments will remain in effect until I choose to revoke them in writing:

_____	_____	_____	_____
(Signature of patient or authorized representative)	**(Printed name)**	**(Date of birth)**	**(Date)**

_____	_____
(If signed above by representative relationship of signee to patient)	**(Name of patient if different from above)**