NAME _____ DATE OF BIRTH _____

assumption of referrals

I understand that if I have insurance coverage, which requires a referral from a Primary Care Physician, it must be received prior to being seen in order to receive the maximum benefits from the insurance company. I further understand that it is my responsibility to know my benefits and obtain a hardcopy referral from my Primary Care Physician. I have been given the opportunity by Contemporary Women's Health, PLLC to obtain a referral or reschedule my appointment. I understand that if I refuse that I am taking full responsibility for payment.

INITIAL _____

authorization to pay insurance benefits to provider

I hereby authorize direct payment to the Physician of any hospital insurance benefits, medical insurance benefits, including Medicare, Medigap, major medical benefits, insurance disability benefits, or injury benefits. I am responsible to pay non-covered services. I also authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE _____ DATE _____

acknowledgement of receipt of privacy notice

I have reviewed a copy of Contemporary Women's Health, PLLC Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by Contemporary Women's Health, PLLC and that I should read it carefully. I consent to Contemporary Women's Health, PLLC use of protected health information as described in the notice. I am aware that the Notice may be changed at any time. I may obtain a current copy of the Notice by calling (865) 540-1650 or by requesting one in person at the office.

SIGNATURE _____ DATE _____

The Privacy Notice and HIPPA Regulations are available for your review at the front desk.

contact notification

Contemporary Women's Health, PLLC will leave confidential messages on your home and/or cell answering machine according to your instructions on the second page of this form. We will safeguard your privacy by limiting the amount of information disclosed. No abnormal tests results relayed by message.

SIGNATURE _____ DATE _____

Please complete all lines requesting your Signature or Initials. This will help in the appropriate timing of your appointment. Thank You!

DATE _____ CHART _____

I have reviewed and/or received a copy of the **Notice of Privacy Practices** for Contemporary Women's Health, PLLC and authorize the release of my **Protected Health Information** as outlined in the policy. This authorization will remain in effect until revoked in writing. A photocopy of this release is to be considered as valid as the original

Contemporary Women's Health, PLLC has my permission to leave appointment and medical information (**INCLUDING NORMAL TEST RESULTS**) with:

Please initial each method that you approve.

___Anyone in my home. ___Spouse/partner only

___At home answering machine. ___Patient only

___At work answering machine or voice mail. ___Cell phone/voice mail

_____

NAME OF PATIENT (Please print)

_____

SIGNATURE OF PATIENT

_____

DATE

_____

Signature of patient representative (Required if the patient is a minor or an adult who is unable to sign this form)

RELATIONSHIP_____

6/18/2009 KR