Dignity Women's Center

Steven G. Pilkington, MD, PLLC
Board Certified Obstetrician & Gynecologist

PATIENT INFORMATIOM:

Patient's Last Name: ______________________ First Name: ______________________

Street Address: ______________________ City: ____________ State: _____ Zip: ________

Date of Birth: ______-______-______ Age: ______ Patients Social Security #: ________________

Hm Phone: ______________ Cell Phone: ______________ Wk Phone: ______________

Marital Status: __________ Race:__________ Ethnicity:__________ Language:__________

Emergency Contact: ____________________ Relationship: __________ Phone: ______________

Primary Insurance: ______________ ID Number: __________________ Group: __________

Name of Policy Holder: ________________ SSN: ______________ DOB: ______________

Secondary Insurance: ________________ ID Number: ________________ Group: __________

Name of Policy Holder: ________________ SSN: ______________ DOB: ______________

Person Responsible for Bill: __________________________ Phone: __________________

Relationship to the Insured: ____ Self ____ Spouse ____Child ____ Other: (please describe) ______________

Street Address: ______________________ City: ____________ State: _____ Zip: ________

Preferred Pharmacy: ______________ Address: __________________ Phone #: __________

How did you hear about us? ____

WILL YOU ACCECPT BLOOD IF REQUIRED FOR HOSPITAL EMERGENCY TREATMENT? YES ( ) NO ( )
INITIALS____ (If your answer is "NO" please notify the receptionist immediately.) As your physician I must practice medicine in the manner that I feel is most beneficial and safe for my patients. Therefore, I cannot accept a patient who will not accept blood for necessary emergency care.
PLEASE BE INFORMED THAT DR. PILKINGTON RECOMMENDS NATURAL METHODS OF FAMILY PLANNING (HE DOESN'T PRESCRIBE ARTIFICIAL METHODS OF FAMILY PLANNING). DR. PILKINGTON DOES NOT PERFORM ABORTIONS. DR. PILKIGNTON DOES NOT PERFORM TUBAL LIGATIONS.

Payment for service is due at the time of service- this includes all PPO/HMO copayments required by the member's contract. PPO/HMO patients will be billed for any "Patient Share" balances not collected after insurance payment. There will be a $30.00 charge for returned checks and these checks will be represented electronically to your account. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for professional services rendered. I have read all the information on this form and have completed the above answers. I have no further questions about these issues and I am requesting medical advice and treatment by Dr. Pilkington. I certify this information is true and correct. I will notify you of any changes in the above information.

Signature: ________________________ Date: __________

I understand and agree that my signature below provides direct assignment of my insurance policy benefits to the doctor for payment of the total charges for professional services rendered. I also authorize the release of any information pertinent to my case to any insurance company or adjuster involved in my account.

Signature: ________________________ Date: __________

Medical History Record

All information is treated as confidential unless you grant permission to release it.

Date:________________

Patient Information

Name:________________________ DOB:________ Phone #:______________ Marital Status:____________

Occupation:__________ * **Drugs you are allergic to**:(and reaction type)________________________________

OB History: (including miscarriages, abortions, and tubal pregnancies)

Delivery Date	Gestation at Delivery	Length of Labor	Birth Weight	Sex of Baby	Delivery Type (Vaginal/C Section)	Name of Baby	Comments (Blood Pressure or Diabetes?)

GYN History:

1. How old were you when you had your first menstrual cycle?______
2. What is the shortest and longest # of days from the start of 1 cycle to the start of the next?____________
3. Have you ever had bleeding between your periods?_____
4. How many days of menstrual flow do you have?_______
5. Do you have very heavy bleeding with your periods?____
6. How many tampons/pads per day on heavy days?________If clots, how big? (dime/quarter/ bigger)
7. Are you now or have you ever taken birth control?______Types and length taking them?____________
8. Have you ever been diagnosed with a STD?(such as herpes, gonorrhea, chlamydia, syphilis, HIV, or abnl pap/HPV)_______
9. Age of first intercourse?__________
10. Number of sexual partners?________
11. If you have had an abnormal pap, when was it?__________
12. When was your last pap smear?____________

Past Medical History: (you or any blood relatives who have or have had any of the listed conditions.)

- Asthma______________
- Arthritis______________
- Allergies______________
- Anemia______________
- Alcoholism______________
- Blood Clotting Disorder__________
- Cancer______________
- Congenital Heart__________
- Diabetes______________
- Epilepsy______________
- Tuberculosis________
- Stomach Ulcers__________
- Kidney Disease__________
- Suicide Attempt____________
- Migraine______________
- Obesity______________
- Thyroid Abnormalities__________
- High Blood Pressure__________
- Stroke______________
- Heart Disease____________

Past Surgical History: (type of surgery & date)

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Prescription Medications: (medication and dose)

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Family Medical History: (immediate blood family, siblings, and children)

Relationship	Age	Health Condition	Living? (Y / N)	Death Cause

Social History:

1. Do you smoke now or in past?________
2. Cigarette's/Day?______________
3. What time frame? (dates)__________
4. How many cups of coffee per day?_____
5. How many drinks/day? (if any)___________

Beer:_____/day Wine______/day Whiskey____/day

6. Any current or past drug use?__________

Dignity Women's Center
4499 Medical Drive Ste. 151
San Antonio, TX 78229
O: (210)593-4392 F: 1(855)300-3785
****Please note new fax number****

AUTHORIZATION TO RELEASE HEALTHCRE INFORMATION
(ONLY NEEDED IF REQUESTIONG RELEASE OF INFORMATION)

Patient's Name: ______________________________ Date of Birth: ______________________
Previous Name: ______________________________ Social Security# ______________________
I request and authorize ______________ to release healthcare information of the patient named above to:

Dignity Women's Center
4499 Medical Drive Ste. 151
San Antonio, TX 78229

This request and authorization applies to:

____Cervical Cancer Screening test and Gynecology related biopsy reports.
____Mammogram Reports
____Bone Density Reports
____Lab results
____Medical Imaging Reports
____Pathology Reports
____Other: ______________________
____ALL OF THE ABOVE

Covering the time period of: ______________________ to ______________________
_____ All treatment events

I realize this authorization includes the release of information about the following: AIDS, HIV related information or testing, psychiatric disorders, drug treatment and genetic testing (unless I request that these not be included). I hereby agree to this authorization and understand that it may contain Personally Identifiable information and PHI as defined in HIPPA to ensure accuracy. I understand I have the right to limit the type of information released and to revoke this authorization by submitting a notice of writing to you. If I chose to limit the information released, I understand that you inform the requestor that portions of the records have been withheld. Dignity Women's Center is not responsible for any incomplete, illegible or omitted information from another institution. I understand that information should be provided within 15 days from the receipt of request and a fee for preparing and furnishing this information may be charged to me according to the rulings set forth by the state of Texas.

Date: ______________ **Unless revoked, this authorization will expire 90 days from the date provided**
Printed Name (patient or patient's legal representative): ______________________________
Signature (patient or patient's legal representative): ______________________________

IF RECORDS ARE MORE THAN 10 PAGES, PLEASE MAIL TO THE ADDRESS ABOVE, DO NOT FAX!
THANK YOU

Dignity Women's Center

Steven G. Pilkington, MD,PLLC

Board Certified Obstetrician & Gynecologist

CONSENT FOR TREATMENT

I request Steven G. Pilkington M.D. and/or his staff (Physician Assistant, Advanced Practice Nurse, Nurse Practitioner, Nurse Midwife or Medical Assistants) to provide treatment for me. This includes, but not limited to: physical examination including pap smear and/or vaginal cultures (for sexually transmitted diseases), injection or medication or vaccines, office procedures, and venipuncture associated with lab tests requested.

Printed Name: ________________________________

Patient Signature: ________________________________

DOB: ________________ DATE: ________________

CONSENT FOR TREATMENT OF A MINOR

I request Steven G. Pilkington and/or his staff (Physician Assistant, Advanced Practice Nurse, Nurse Practitioner, Nurse Midwife or Medical Assistants) to provide treatment for the minor listed below. I affirm that I am legally authorized to request medical care for her. This includes, but not limited to: physical examination including pap smear and/or vaginal cultures (for sexually transmitted diseases), injection or medication or vaccines, office procedures, and venipuncture associated with lab tests requested.

Minor Patients Name: ________________ DOB: ________________

Printed Legal Parent/Guardian Name: ________________________________

Legal Parent/Guardian Signature: ________________ DATE: ________________

UPDATED: 03/06/2024

HEALTH INSURANCE ATTESTATION FORM

I, ______________________ attest that I have the following Health Insurance(s). I understand that it is my responsibility to inform Dignity Women's Center should my policy change or I no longer have coverage. I also understand that should my claim(s) be denied by my insurance(s), I will be responsible for the amount of the office visit.

Primary Insurance
Policy Name:
Policy Number:

Secondary Insurance
Policy Name:
Policy Number:

Tertiary Insurance
Policy Name:
Policy Number:

Quaternary Insurance
Policy Name:
Policy Number:

Patient Name:

Patient Signature:

Date:

PRIVIA
MEDICAL GROUP

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

HIPAA. I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: ______________________________ **Email:** ________________________

➔ Signature: ____ **Date:** ______________

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent

Name and Relationship of Person Signing, if not Patient: ____

**Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.*

Dignity Women's Center

ELECTRONIC APPOINTMENT REMINDER REQUEST & CONSENT

Dignity Women's Center has now made it even easier for you to receive reminders about your Well Woman Exam. We can now email your reminders! This makes the process quick & easy!

☐ YES! I would like to receive reminders about my yearly Well Woman Exam via email.
My email address is: ______________________________.

☐ YES! I would like to receive reminders about my yearly Well Woman Exam via text message.
My cell phone number is: ______________________________.

I understand that it is my responsibility to inform Dignity Women's Center in writing if my preferences change or if my email address and cell phone changes. I understand that failure to do this could result in me not receiving a notice. I also understand that email can be vulnerable to unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. I also understand that reminders for yearly exams are a courtesy of Dignity Women's Center and that failure to receive one is not an indication that one is not needed. It is my responsibility to schedule a Well Woman Exam yearly.

______________________________ ______________
Patient name (Printed) Date of Birth

______________________________ ______________
Patient Signature Date

Dignity Women's Center

Steven G. Pilkington, MD, PLLC
Board Certified Obstetrician & Gynecologist

****FOR ALL PREGNANT WOMEN AND INTERESTED GYN PATIENTS ****

CONSENT FOR HUMAN IMMUNDODEFIENCY VIRUS (HIV) TESTING

I, ______________________________ understand that a sample of my blood will be taken and tested by ELISA and/or Western Blot methods for the antibodies to the Human Immunodeficiency Virus (HIV).

I understand that the ELISA and Western Blot tests are very accurate. However, a very small percentage of tests (less that 0.5%) may give a false positive or a false negative result. A false positive means that the test has incorrectly Indicated that I am infected with HIV when, in fact, I am not. A false negative result means that the test has incorrectly Indicated that I am not infected with HIV when, in fact, I am. A small percentage of the test results may be labeled "equivocal", "unsatisfactory", or "inconclusive", and may require additional testing.

I understand that there is a chance that, if I have been Infected with the virus recently, my body may not yet have made sufficient antibodies to be detected by the test.

I understand that the performance of and the results of the HIV antibody test are confidential.
I HEREBY CONSENT TO BE TESTED FOR THE HIV ANTIBODY:

____
SIGNATURE OF PATIENT/ GUARDIAN

____
DATE

Dignity Women's Center

Steven G. Pilkington, MD, PLLC
Board Certified Obstetrician & Gynecologist

APPOINTMENT POLICY

Our goal is to satisfy our patients with exceptional care. Whether you are seeing us for a routine, annual well woman exam or for a problem visit, we take the time to discuss the issues and answer your questions. The current state of managed care has placed severe limits on what can be done in a single visit. An "annual well woman exam visit" only allows time for the discussion of a preventive medicine problem. Please schedule a "problem visit," not an "annual well woman exam" visit for any other problems. These are two very different types of visits (per insurance company requirements). Therefore, if you have a medical problem at the time of your well woman exam, a "problem visit" will need to be scheduled for you on another day. If the medical problem is emergent or if you choose to do so, we will address the problem and reschedule the "well woman exam" for another day.

We have done our best to explain this aspect of the confusing world of managed care. If you have further questions about this, please ask us or your insurance company.

CANCELLATION POLICY

We value our patients and the time we spend with each of you. We would like to set aside appointments that work for your schedule. Therefore see patients before 8 am and at the noon hour. If there is a conflict with your scheduled appointment time, we ask that you call our office at least 24 hours in advanced to cancel or reschedule. When you schedule an appointment we cannot offer that time slot to other patients needing to be seen. For this reason, appointments cancelled without a 24 hour advanced notice incur a $35.00 fee.

By signing this letter you are stating you have read and understand the appointment/cancellation policies outlined on this page and have no further questions.

Patient Name: (print): ____

Patient Signature: ______________________________ Date: ________________

CREDIT CARD ON FILE POLICY

At Dignity Women's Center, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover for which you are responsible. Without this authorization, a billing fee of $300.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Dignity Women's Center to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover
Credit Card Number ______________________________

Expiration Date _____ / _____ / _____

Cardholder Name ______________________________

Signature ______________________________

Billing Address ______________________________

City ____________________ State______ Zip __________

I (we), the undersigned, authorize and request Dignity Women's Center to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Dignity Women's Center. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Dignity Women's Center in writing and the account must be in good standing.

Patient Name (Print): ______________________________

Patient Signature: ______________________________

Date: _____ / _____ / _____

NOTICE OF PRIVACY PRACTICES FOR DIGNITY WOMENS CENTER

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used, "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by ("HIPAA") we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment. Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute, de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You many revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. The right to inspect and copy your protected health information. The right to amend your protected health information. The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain he privacy of your protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14th 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of out Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protection has been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health &Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Notice of Privacy Practices Acknowledgement For
Dignity Women's Center

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly

- Obtain payment from third-party payers

- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I HEREBY AUTHORIZE THE FOLLOWING INDIVIDUAL(S) TO CONSENT TO TREATMENT OR SERVICES, AND TO VERBALLY GIVE AND RECEIVE PROTECTED HEALTH INFORMATION REGARDING ANY TREATMENT OR SERVICES RENDERED AT DIGNITY WOMEN'S CENTER. IF ANY CHANGES OCCUR TO THIS AUTHORIZATION IT WILL BE MY RESPONSIBILITY TO NOTIFY DIGNITY WOMEN'S CENTER.

NAME DOB RELATIONSHIP TO PATIENT

1.____
2.____
3.____

_________________________________ __________
Signature of Patient or Representative/Guardian Date

____
Printed Name of Patient or Representative/Guardian

PRIVIA MEDICAL GROUP

FINANCIAL POLICY

We are pleased that you have chosen us as your healthcare provider. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care.

We require all patients sign our *Authorization and Consent To Treatment Form* before receiving medical services. That form confirms that you understand that the healthcare services provided are necessary and appropriate and explains your financial responsibility with respect to services received as set forth in this policy.

PATIENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. When the insurance plan provides immediate information regarding patient responsibility, we may request payment for your share when you schedule and/or when you present for your appointment. As a convenience to you, we can save a credit card on file to settle your account when you check in or out.

You may receive an estimate for your patient responsibility prior to or at the time of your service. If there is a difference in the estimated patient responsibility, we will send you a statement for any balance due. If a credit balance results after insurance pays, we will apply the credit to any open balance on your account. If there are no open balances, we will issue a refund.

If you have an Annual Wellness Visit or Physical/Preventative Exam, but need or request additional services, we may bill you for those additional services. All services for patients who are minors will be billed to the custodial parent or legal guardian. If you are uninsured and demonstrate financial need and complete the required paperwork, financial assistance may be available. If you have a large balance, a payment plan may be available.

INSURANCE

We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay). We accept assignment of benefits for many third party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient responsibility. Keep in mind that our fees are for physician services only; you may receive additional bills from laboratory, radiology or other diagnostic related providers.

You are responsible for understanding the limitations of your insurance policy, including:

- If a referral or authorization is necessary for office visits. (If it is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient).
- What prescribed testing (lab, radiology, etc.) is covered under your insurance policy. (If you choose to have non-covered testing, we will require full payment at the time of your visit.)
- Any co-payment, coinsurance or deductible that may apply

NO SURPRISES ACT / GOOD FAITH ESTIMATE OF CHARGES

If you do not have insurance or are not using insurance to pay for your care, you have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

Under the NO SURPRISES ACT, health care providers must give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least one (1) business day before your medical service or item.
- You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-888-774-8428.

CARD-ON-FILE PROCESS

You may be requested to provide a credit card when you check-in for your visit. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of the notice. You may call our office if you have a question about your balance. We will send you a receipt for the charge.

This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork and ultimately helps lower the cost of healthcare. Your statements will be available via your patient portal and our Customer Support line is available to answer any questions about the balance due. If you have any questions about the card-on-file payment method, please let us know.

YOUR RESPONSIBILITIES

Outstanding Balances. After your visit, we will send you a statement for any outstanding balances. We send out statements when the balance becomes the patient's responsibility.

All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. Your outstanding balances can be paid conveniently via our patient portal.

We may add a finance charge of 1.33% of your outstanding account balance every month if you do not pay your account in full.

If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a collection fee of 23% of the balance owed, or whatever amount is permitted by applicable state law, in addition to the balance owed. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made.

No-shows. If you miss your appointment, you may be charged a $50.00 fee for a missed appointment, a $75.00 fee for a missed pediatric appointment, a $100.00 fee for a missed physical, or a $200 fee for a missed procedure or surgery. This fee will need to be paid before you are allowed to schedule another appointment. This fee cannot be billed to insurance.

Interpreter and Translation Services. If you have requested interpreter or translation services for your visit and you miss your appointment without cancelling at least forty-eight (48) hours prior to your scheduled appointment, you may be charged the amount that the translation or interpreter service charges your care center for such missed appointment.

Additional information about our financial policies is available on our website at priviahealth.com.

Thank you for choosing us as your healthcare provider!

HEALTH INSURANCE ATTESTATION FORM

I, ______________________ attest that I have the following Health Insurance(s). I understand that it is my responsibility to inform Dignity Women's Center should my policy change or I no longer have coverage. I also understand that should my claim(s) be denied by my insurance(s), I will be responsible for the amount of the office visit.

Primary Insurance
Policy Name:
Policy Number:

Secondary Insurance
Policy Name:
Policy Number:

Tertiary Insurance
Policy Name:
Policy Number:

Quaternary Insurance
Policy Name:
Policy Number:

Patient Name:

Patient Signature:

Date: