Patient Name: _____ Date of Birth: _____

Consent for Treatment:
I understand that if my health condition requires outpatient admission, I authorize and consent to treatments ordered by my physician.

Initials:	
Date:	

Consent for Photo and Study:
I authorize and consent to Virtuosa Women's Health and/or Dr. Crockett to use my photo of procedures done by Dr. Susan A. Crockett for studies, educational teachings, journals and presentations.

Initials:	
Date:	

Release of Medical Information
I consent to release of all my medical records, without limitation, to any insurance company or other party which may be responsible for payment of all or part of my medical expenses.

Initials:	
Date:	

Attendance Policy:
We respectfully request 24 hours advance notice of appointment cancellations. If appointments are not kept, your treatment, prescriptions or future care may be terminated after a third (3rd) No Show. **For every NO SHOW there will be a $50.00 fee added to your account, which will need to paid prior to your next appointment.**

Initials:	
Date:	

Results & Appointment Policy:
We do not give results over the phone. All normal results will be posted to your patient portal. All out of range or abnormal results will need a follow appointment. Please be aware that per your insurance every appointment you are seen we will collect copay, deductible and coinsurance amounts.

Initials:	
Date:	

Patient Bill of Rights & Notice of Privacy Practices:
I certify that I have received a copy of the Patient Bill of Rights and the Notice of Privacy Practices prior to being seen in the clinic. (A copy will be given to you at your request.)

Initials:	
Date:	

Financial Policy:

Thank you for choosing Virtuosa Women's Health as your healthcare provider. We are committed to providing you the best available medical care. Our personnel will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our Patient Information form prior to seeing the physician.

Payment for service is due at the time services are rendered. We accept cash, check, Visa, American Express, Discover, and MasterCard. We will be happy to help you process your insurance claims for your reimbursement.

We accept assignment of insurance benefits. However, you must understand that

1) Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. We are however, contracted with certain managed care, and preferred provider plans; we will follow the guidelines for patient care, reimbursement, and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.

2) **All charges are your responsibility whether your insurance company pays or does not pay.** Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3) **Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.**

4) **If your insurance company does not pay your claim within 30 days,** it is your responsibility to contact your insurance to expedite payment. You will be responsible for any unpaid claims.

5) **If your insurance company does not pay in full within 45 days,** we require you to pay the balance by cash, check, Visa, American Express, Discover or MasterCard.

6) Lab billing – **Please remember; your lab billing is separate from our physician's billing and you may receive a separate itemized bill from the laboratory,** for which you are responsible. Please verify that you are being directed by our office to a lab that is a participating provider with your insurance plan.

7) **Returned checks and balances older than 45 days may be subject to collection placement and collection fees.**

8) **FMLA/Disability Forms charge is $45.00,** due at time of request.

_____ _____

Patient/Guardian Signature Date