Northern Bay Womens Health Center P.A.
Dr. Irwin Endelman, M.D.,F.A.C.O.G

Patient Name: DOB:

Consent to Treatment:

I hereby give my consent for medical treatment by the physicians or under the direction of the physicians of Northern Bay Womens Health Center P.A.

Initial:

Payment Policy:

I understand that I am responsible for payment of professional services at the time they are rendered. I understand that I am responsible for any amount covered by insurance including, without limitation, deductible, co-payment, co-insurance, or other amounts unpaid by my insurance, if benefits assigned.
Northern Bay Womens Health Center P.A.
files claims for Medicare assignment and only the managed care plans,
which we are contracted. Claims will not be filled with other insurance carriers. If you plan to pay by check and it is dishonored a processing fee of $35 will be assessed.

Initial:

Assignment of Benefits:

I assign to the treating physicians of Northern Bay Womens Health Center P.A.
all payments for medicals services
rendered to my dependents or myself for services filed to insurance on my behalf.

Initial:

Authorization for Release of Medical Information:

I certify that I have received and read a copy of the "Notice of Protected Health Information Practices". I hereby authorize Northern Bay Womens Health Center P.A.
to release any of my medical or incidental information
that may be necessary for medical care or to process medical insurance claims.

Initial:

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friend(s).

Name: Relationship: Phone:

Name: Relationship: Phone:

I do not wish my information to be disclosed to any person

Initial:

Authorization to Mail, Call

I certify that I understand the privacy risks of the mail, phone calls and email. I hereby authorize a representative or my physician to mail, call or email me with communications regarding my healthcare, such as appointment reminders and/or medical information regarding patient care. I understand that I have
the right to revoke consent for any and all of the above initialed items at any time in writing.

Initial:

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information and payment of any services not covered or approved by my insurance carrier.

Signature of Patient or Authorized Representative Date