Fair Oaks Women's Health
Obstetrics and Gynecology
625 South Fair Oaks Avenue
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Pasadena, CA 91105

Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

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CONSENT AGREEMENTS

OFFICE FINANCIAL POLICIES

By signing below, I acknowledge that I have read the handout regarding the FOWH Financial Policies and I agree to all the provisions in it. I will update the office whenever my health insurance policy changes. I authorize a credit card on file to be used for unpaid balances due. I will keep all scheduled appointments and arrive at least 15 minutes early for check-in procedures. I will notify the office at least 24 hours in advance if I cannot keep a scheduled appointment.

Initials ______

OB FEES POLICY

By signing below, I acknowledge that I have read the handout on FOWH OB Fees Policy, and I agree to it. I authorize the physicians of Fair Oaks Women's Health to furnish all necessary information to my insurance carrier(s) concerning my medical care and treatment. I also irrevocably assign to Fair Oaks Women's Health all insurance payments for services rendered and all major medical benefits. I understand that **I am personally obligated to pay for all medical services rendered** regardless of whether or how much my insurance company has paid.

Initials ______

OB SONO CONSENT

By signing below, I acknowledge that I have read the handout regarding the FOWH Ob Ultrasound Policy and I agree to it. I have been advised that the physicians at Fair Oaks Women's Health require a minimum of 3 ultrasound examinations during my pregnancy in order to provide optimal obstetrical care. I have been advised that if my health insurance provider denies coverage for some or all of these 3 ultrasounds, I will be financially responsible for their cost, in addition to my obstetrical care fee. I am aware that I can appeal the insurance denial and that Fair Oaks Women's Health will assist me in doing so.

Initials ______

COST OF NIPT (Non-Invasive Prenatal Test, or cell-free DNA blood test)

By signing below, I acknowledge that I have read the handout regarding the Cost of Testing for prenatal DNA (NIPT and/or genetic carrier screening) and I agree to it. I understand the issues discussed in the handout. I am aware that it is ultimately my responsibility to determine if my insurance will pay for these tests or not, and what my out-of-pocket costs might be.

Initials ______

HIPAA DISCLOSURE

By signing below, I acknowledge that I have read the handout regarding the Notice of Privacy Practices and I agree to it. I hereby authorize Fair Oaks Women's Health to discuss/reveal the following personal protected health information with the person(s) listed below:

____ Any or all of my medical care, treatment and/or test results
____ Same as above except: ____
____ Only the following information: ______________________________________
____ I do not authorize any disclosures to others (except when permitted as specified in the Practice Privacy Notice)

Authorized person(s) Provide Name and Relationship:

____
____

Initials ______

PATIENT NAME ______________________________ DATE ______________

PATIENT SIGNATURE ______________________________