LOUISIANA WOMEN'S Healthcare | Ochsner

500 RUE DE LA VIE, SUITE 100 • BATON ROUGE, LOUISIANA 70817 • 225-201-2000

Pat. Name _____

Date of Birth _____

Patient I.D. _____

Physician _____

AFFIX LABEL HERE

Patient Authorization and Financial Agreement

I consent to and authorize Louisiana Women's Healthcare (LWH) to provide diagnostic procedures, medical procedures including minor procedures and routine services at the time of my office visit.

I authorize the release of all medical records, including any and all records containing HIV, substance abuse, behavioral health, or genetic information, to my insurance company if applicable. I further consent to the sharing of my health information with my other healthcare providers if requested.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to the physician. I further authorize and direct my insurance carrier(s) to pay directly to Louisiana Women's Healthcare any insurance benefits due for services rendered on behalf of me or the named patient.

LWH participates with a variety of insurance plans. It is my responsibility to bring my current insurance card and driver's license to every visit to ensure LWH has the correct filing information. Eligibility for coverage by health insurance plans is not a guarantee of benefits. If it is determined that I am not eligible for coverage, I will be required to pay in full for all services rendered.

I am required to pay any insurance co-payments, deductibles, coinsurance, and/or non-covered charges at the time of service. LWH accepts cash, check, Visa, Master Card, Discover, and American Express. I understand I am financially responsible for any and all charges not paid by my insurance company. All NSF checks will incur a $25 charge.

If it becomes necessary to collect my financial responsibility through an attorney, then, I agree to pay all reasonable costs of collection including attorney's fees, whether suit is filed or not. Additionally, I agree to pay court costs associated with such collection efforts.

I understand that precertification or prior approval may be required by my health plan before certain procedures, or surgeries are performed. This process can take several days or weeks depending on the insurance plan. LWH will contact my insurance company on my behalf; however, it is my responsibility to confirm benefits and approval by my insurance prior to receiving services.

I understand that I may be responsible for charges related to completion of forms (FMLA, short-term disability applications) and medical records fees. Copies of medical records will be charged to the requesting party by the copying company. These fees will not be filed to my insurance.

I authorize LWH to contact me using automated voice messaging, text messaging, and/or email to any telephone number or email address that I provide. This may include, but not limited to, appointment reminders, health and wellness reminders, and marketing materials from LWH and its affiliates.

I understand that LWH may choose to discontinue treatment and/or terminate care of any patient due to the following: failure to meet financial obligations; noncompliance with treatments, follow-up appointments, or medication recommendations; or rude, inappropriate, or egregious behavior.

I acknowledge that I have been given the opportunity to review and receive a copy of LWH's Notice of Privacy Practices.

This authorization will remain in effect until revoked by me in writing.

_____ _____

Patient Signature Date