

WOMEN'S HEALTH NOW
LINO OSSANNA, M.D.
21321 E OCOTILLO RD, SUITE 127
QUEEN CREEK, AZ 85242
480.888.7271

CONSENT FOR TREATMENT AND INSURANCE AUTHORIZATION AND ASSIGNMENT
(PLEASE READ COMPLETELY AND SIGN)

1. The patient or authorized person agrees that the demographic information is correct and allows for the medical treatment as specified by physician or associate provider.
2. I hereby authorize Women's Health Now to furnish information to insurance carriers concerning my illness and treatments and I hereby assign the physicians ALL payments for medical services rendered to myself or my dependents. I understand that I am responsible for ANY unpaid amounts, and agree to pay service charges at the current rate, collection charges, and accounts that become 30 days overdue are subject to a 1.5% monthly service charge. There will be a \$25.00 charge for returned checks and all future payments will be made by debit/credit card, money order, or cash. NO EXCEPTIONS.
3. I understand that office visits, consults, treatments and procedures with the physician are SEPARATE charges from any Laboratory testing that is determined to be medically necessary or are performed as a matter of course in my examination. Examples of these tests are blood tests, urinalysis, pap smears, cultures, biopsies, or any other test that involves the taking of bodily fluid or tissue as a specimen for examination. These tests are sent to a Laboratory with charges for handling and processing that are separate from Women's Health Now and I understand that it is possible that based off of my insurance or cash pay status that I may be billed from the Laboratory.
4. I am aware that for any disability forms, FMLA forms, paperwork, etc. that there is a \$20.00 fee per set of forms.
5. If I am unable to keep an appointment, procedure, or an ultrasound a 24 hour notice is required or a \$25.00 charge will be made for the missed appointment.
6. I understand that I am responsible for notifying the office of all insurance changes including any secondary insurance information if I do not inform the office I understand that I will be responsible for any remaining balances

E-MAIL ADDRESS _____

Furthermore, I give permission for the following persons ONLY to be given my Personal Health Information (PHI):

A. _____ Relationship to Patient: _____

B. _____ Relationship to Patient: _____

This authorization will be in effect for one year unless it is revoked at an earlier date by the patient.

Print Patient Name _____ Date _____

Signature of Financially Responsible Party _____

Witness Signature _____ Date _____