Patient Acknowledgment & Signature Form

FINANCIAL POLICY **Initials____________________**

DrNGyn values the confidence you have shown in choosing us as your health care provider. You should be aware of what services your insurance may or may not cover. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill, including deductibles, co-payment/co-insurance and non-covered services as determined by your contract with your insurance carrier. Co-pays are due at the time of service. If you are unable to furnish us with current insurance information at the time of service, charges will become your responsibility. We may require a deposit for certain services

You will receive a monthly statement showing the activity and balances due on your account. DrNGyn accepts cash, checks, MasterCard Visa and Discover. Unless payment arrangements have been made in advance, any remaining balance owed by you is due in full when you receive your first bill. A $25 bank fee will be charged for NSF checks. We offer a payment plan option for qualified patients who are unable to pay their balance in full. Patient balances left unpaid may be turned to an outside collections agency. Separate billings may be received for laboratory, anesthesiology, radiology, hospital services and "on-call" or other providers who are involved in your care which are subject to their financial policies.

SELF PAY PATIENTS **Initials____________________**

Patients without insurance are required to pay in full at the time of service, unless other arrangements have been made. Self-pay GYN patients are offered a 20% discount on all services paid in full at the time of service. Aesthetic procedures and ThermiVa, Mona Lisa Touch and Emsella, do not apply.

NO-SHOW & CANCELLATION POLICY **Initials______________________**

As a courtesy to Dr. Salisbury, we request **24 Hours'** notice for any office appointment you will not be able to keep. Patients scheduled for surgical procedures in the office or hospital are required to give **ONE WEEK** notice for any non-emergent cancellation or reschedule. Failure to provide timely notice, or repeatedly neglecting to show up for your scheduled appointment(s), may result in a cancellation fee of up to $50, the forfeit of all deposits paid and /or termination from the practice.

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGMENT & CONSENT **Initials_______________________**

I understand that DrNGyn will use and disclose health information about me. I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I understand and agree the DrNGyn may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among and manage along with other health care providers for my care and treatment
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or other who may be responsible to pay for some or all of my health care.
- Perform various offices, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how DrNGyn will handle health information about me. This written description is known as the Notice of Privacy Practices my be revised from time to time, and that I am entitled to receive a copy of any revision. I also understand that a copy of the most current version of the Notice o Privacy Practices will be posted in reception areas and available on the website at www.drngyn.com. I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that DrNGyn in not required by law to agree to such requests.

BENEFIT ASSIGNMENT

By signing below, I authorize DrNGyn to bill my insurance on my behalf, and assign all benefits, if any, directly to DrNGyn, that otherwise would be payable to me for services rendered. I authorize the use of my signature on all insurance submissions. This consent will continue indefinitely unless revoked by me in writing.

GENETIC RESEARCH OPT-OUT **Initials________________________**

Oregon Law allows you to decide whether you are willing to allow your medical information to be used for coded or anonymous genetic research. If you DO NOT want your information used for future coded or anonymous genetic research, please indicate by initialing here.

PATIENT/PATIENT REPRESENTATIVE SIGNATURE

By signing below, I acknowledge that I have read and understand all information included in this policy.

______________________________________	___________________________	____________________
Patient/Patient representative signature	**Relationship (if not patient)**	**Date**

If you have any questions about this policy, please see a representative in our office. We appreciate the opportunity to serve you. (effective 07/01/2011)