PineRidge
Obstetrix & Gynecology Inc.

Patient Agreement Form

___ I authorize medical healthcare and treatment by PineRidge Ostretix & Gynecology Inc.

___ I understand that all refills, referrals and letters will be taken care of at the time of an appointment.

___ I agree to a $20.00 fee for any returned checks.

___ PineRidge Obstretrix & Gynecology Inc. notifies patients about the results of all tests that are ordered, regardless of whether the findings are normal or abnormal. Occasionally, the results do not get sent to the office. If you have undergone routine medical testing and have not received the results within 14 business days, please call the office to ensure that the results of all completed tests are reported back to you.

___ I acknowledge that I have reviewed a copy of the Notice of Health Information Privacy Practice, and have taken a copy if desired.

___ I authorize PineRidge Obstetrix & Gynecology Inc. to release my medical information to any Physician or Healthcare Practitioner to whom I am being referred for care and to any payer of my care including my insurance company or managed care program upon their specific request. This also extends to records regarding my child, if applicable.

___PineRidge Obstetrix & Gynecology Inc. respects your privacy and will only release information required to further your treatment, assist you in obtaining payment, managing her own internal operation, or as specifically authorized by you.

___I understand that I am responsible for all charger incurred for treatments rendered, even if my Insurance company determines that any services are non-covered or excluded.

___I may revoke these authorizations in writing at any time. Such revocation will not affect my financial Responsibility to pay for services rendered.

Patient Signature_____ Date_____
(or Guardian's Signature, If patient is a minor)