Women's Wellness Comprehensive Care
535 Ocean Avenue Suite 4
Portland, ME, 04103

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA "NOTICE OF PRIVACY PRACTICES"

I acknowledge receipt of the Notice of Privacy Practices prepared by Casco Medical Group, LLC/WWCC. I understand that if I have any questions about the practices Notice of Privacy Practices, I may speak with the HIPAA Officer.

_____ _____
Name of Patient (please print) Date of Birth

_____ _____
Signature of patient or legal guardian Date

CONSENT TO TREATMENT

I authorize WWCC, staff, and other individuals involved in my care to examine me, and perform any tests, procedures, and/or treatments that may be helpful. I understand that the health care practitioner responsible for this care will explain any proposed procedures or treatments, including their usual and most common risks and hazards. I also understand that I have the right to refuse any proposed procedure or treatment.

_____ _____
Signature of patient or legal guardian Date

AUTHORIZATION FOR BILLING AND PAYMENT

I understand that I am responsible for paying all costs associated with my care and treatment. If I have health insurance, I authorize WWCC and Casco Medical Group, LLC to bill my insurance directly. I also understand that I am financially responsible in the event that some or all payment is denied by my insurance carrier or other third party payor. I am also responsible for charges not covered by my insurance, such as deductibles, copays, or full payment for non-covered services. I authorize my health insurance carrier(s) or other third parties that are responsible for my care to make payments directly to WWCC.

**Medicare Patients: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care of Financing Administration or its intermediaries or carriers and information needed for this release or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Signature of patient or legal guardian Date

Casco Medical Group, LLC/WWCC regards the safeguarding of your confidential health care information as an important duty. The elements of this authorization to disclose are required by state law for your protection and to ensure your informed authorization to the disclosure of health care information necessary to support your relationship with your physician.

I, _____, authorize Casco Medical Group, LLC/WWCC to disclose my health care information to health care practitioners and facilities that are involved in providing medical services to me. I understand that Casco Medical Group, LLC/WWCC will disclose such health care information which is necessary, in the judgment of my physician, for the legitimate needs of the recipient or for my general well being. **Also, I authorize Casco Medical Group, LLC/WWCC to disclose my health information to my health insurance carrier, utilization review organization, or benefit manager or any other third party who may be responsible for payment for services rendered to me.**

My health information, which is the subject of this authorization to disclose, includes demographic information, information about my physical or mental health or condition, information about the medical services provided to me, including payment information. Depending on the services that I request from my physician, this information may include information about treatment for sexually transmitted diseases, mental health, or substance abuse.

I understand that I have a right to restrict Casco Medical Group, LLC/WWCC use and disclosure to my health care information and that they are not obligated to agree to the requested restriction. If they do agree, Casco Medical Group, LLC/WWCC will honor the restriction. I may revoke this authorization at any time by providing a written, signed and dated request to the attention of the Office Manager at Casco Medical Group, LLC. The revocation will apply except to the extent where information has been released prior to receiving the written notice. However, I understand that any restriction on the use and disclosure of protected health information or revocation of this authorization may result in improper diagnosis or treatment, a denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.

I understand that if I have any questions about this authorization or if I wish to have a copy of this form, I may ask the office staff.

_____ _____

Signature of patient or legal guardian Date