PHI Communication Form

Patient Identification

Printed Name: ___________________________________ Date of Birth: ______________________

Address: ____ Last 4 digits of SSN: _______________

____ Telephone: ________________________

I, ____, hereby authorize release of my Protected Health Information for discussion of my care or treatment to the person(s) specified below.

Authorized person(s) to receive **verbal** information regarding the above patients care:

___________________________	___________________________	____________________
Printed Name	Relationship to Patient	Telephone
___________________________	___________________________	____________________
Printed Name	Relationship to Patient	Telephone
___________________________	___________________________	____________________
Printed Name	Relationship to Patient	Telephone

Note: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record.

Aspen Women's Center will not release paper or electronic copies of your medical record to any one including those listed above unless an ***Authorization for Use and Disclosure of Protected Health Information*** form is completed or Aspen Women's Center is already permitted by law to do so.

Aspen Women's Center may still speak to other persons not listed on this form about your care if otherwise permitted by law.

I understand I may revoke this authorization at any time and Aspen Women's Center will cease discussing my Protected Health Information with the above person(s) upon receipt, unless otherwise relied upon or if Aspen Women's Center is not otherwise required by law to share information with the above person(s).

Patient or Legal Personal Representative: ______________________________ Date: _____________
Signature

Patient or Legal Personal Representative: ______________________________ Date: _____________
Printed Name

Authority of Personal Representative: __________________________________

Patient Name:
MRN#:
Date of Birth:

Name: ______________________________

DOB: ______________________ MR#: ______________________

Physician and Hospital Services Agreement

1. **Annual Consent for Services:** I agree to the services that may be performed by an Aspen Women's Center (referred to as AWC for the rest of this document) physician or non-physician provider ("provider") or facility. I understand I can withdraw this agreement at any time. This agreement applies to any provider services I may obtain from AWC providers at a clinic or physician's office and also to any hospital services I may obtain from an AWC provider while in the hospital. I understand that except in an emergency, no major procedure or treatment will be performed without providing me an opportunity to give informed consent, meaning the provider will first provide me with information including the nature of the procedure or treatment, risks, benefits, and alternatives.
2. **Telehealth Services:** I give my permission for consult-based services that may be provided to me from another location by live video technology ("telehealth"). I understand that I can withdraw this permission at any time by telling my provider when telehealth services are recommended to me and that if I choose to withdraw this permission, there may be certain services that I am not able to receive at AWC. I also understand and agree that: (i) I may refuse telehealth services at any time without affecting my right to future care or treatment and without risking any third party payor benefits to which I am entitled; (ii) I will be informed of the alternatives, if any, to the telehealth services that are available to me; (iii) I will have the right to access the medical record of the telehealth services as provided by law; (iv) I give my permission for the sharing, storage, and retention of identifiable images or other information from the telehealth service, with the understanding that like in-person care, any identifiable images or other information will not be shared except as required or permitted by law; (v) I have the right to know who will be present during the telehealth services and may exclude anyone from either location; and (vi) there will be no videotaping or recording of telehealth services.
3. **Financial Agreement:** I guarantee and agree to pay for all goods and services provided to me or the patient named below at the rates listed in AWC's Charge Description Master as of the date of treatment, or a different amount as may be determined under my (or the patient's) insurance plan(s) or my (or the patient's) status as a Medicare or Medicaid beneficiary. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses.
4. **Assignment of Insurance Benefits:** I assign to AWC, my physician or other non-AWC health care professionals involved in my (or the patient's) care my (or the patient's) rights under all insurance and benefit plan documents, and authorize direct payment to each health care provider of all insurance and plan benefits payments for services provided to me (or the patient) by these providers. By paying my providers directly, my insurance company or employer is fulfilling its obligations to me (or the patient) under the insurance policy, or the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.
5. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payor, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made in my (or the patient's) behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my (or the patient's) eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize AWC to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

Name: ____
DOB:__________________________________ MR#:___________________________

6. **Notice of Privacy Practices:** I acknowledge that I have received a copy of the Notice of Privacy Practices (NOPP), which describes when AWC may use or disclose information for treatment, payment and health care operations. The NOPP is considered part of this Agreement by this reference. I understand that the NOPP is only provided the first time I receive services from AWC and is otherwise available upon request and on AWC's website.
7. **Images and Monitoring:** I understand that AWC may make and use recordings, films, or other images for identification, diagnosis, treatment, performance improvement, or educational purposes. I understand that AWC may provide or make available monitoring services through mobile application, medical device, or other technology. I understand that AWC may use video monitoring in patient care areas when there is clinical need and in common areas for security purposes. I consent to such images, technology and video monitoring, with the understanding that any images, audio, or data are not readily available to visitors or the public and will not be disclosed except as required or permitted by law.
8. **Legal Relationship between Hospital and Provider:** I understand that when I am hospitalized, I am under the care and supervision of my attending provider, and it is the responsibility of the hospital and nursing staff to carry out his/her instructions. It is the responsibility of my provider or surgeon to obtain my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under instruction of the provider.
9. **Clinic Rules:** I understand that my visitors and I must obey all AWC clinic. I understand that if I or my visitors do not follow the rules, AWC may pursue corrective action.
10. **Personal Valuables:** I understand that as a patient, I am encouraged to leave valuable personal items at home. AWC is not responsible for the loss or damage to these items.
11. **Demographic Information:** I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform AWC of any changes as soon as possible.
12. **Independent Contractor/Provider:** I understand that separate bills may be sent for professional services from non-AWC providers such as radiologists, pathologists, and anesthesiologists, in addition to the AWC bill.
13. **Phone Calls, Text Messages:** I authorize AWC and its collection agencies to contact me, or a representative I appoint, about my account or my experience, including using any contact information or cell phone numbers that I have provided or will provide, or that is available to AWC from third parties. I authorize contact with me by telephone, voice message, and text message and authorize the use of automated dialing and texting technology and artificial or pre-recorded voice, even if I am charged for the call or text under my phone plan. I agree such contact will not be "unsolicited" for purposes of local, state or federal law. I agree that AWC and its collection agencies may monitor and/or record any communication.

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to sign for the patient and accept the terms written above. A signed copy of this form is available upon request.

Signature: ____ Date: ______________

If signed by other than patient, indicate relationship: ____

Participation in Secure Health Information Networks
Authorization and Consent Form

What are you agreeing to by signing this form?

- To give your permission to allow your health care providers to share your health records electronically, through their computers, to better care for you.
- That you have received information about sharing your health records through secure Health Information Networks.

Please read the statements below.

(If you are a patient's legal representative, "me", "my", or "I" refer to the Patient)

By signing this form, I understand and agree that Aspen Women's Center participates in my state's Health Information Network as well as the National Health Information network. Aspen Women's Center and other participants in these networks will:

1. Will be able to see all of my health records from both before and after today's date.
2. May use or share my health data, but only as allowed by federal and state laws. This is the same as for my health records in paper form.
3. May share *all* of my health records with providers who are treating me; this includes but is not limited to:
   - Illnesses or injuries (like diabetes or a broken bone)
   - Test results (like X-rays or blood tests)
   - Medicines that I am taking or have taken

   This also may include, but is not limited to sensitive data:

   - Alcohol or substance abuse problems
   - Genetic (inherited) diseases or tests
   - Mental health and developmental disabilities
   - HIV/AIDS
   - Head and spinal cord injuries
   - Family planning information (including abortions)
   - Sexually transmitted diseases
4. May copy or include my information in their own medical records when caring for me. Even if I later cancel my consent, providers I've visited who have copied my records are not required to remove them. This is the current law.
5. Have penalties in place for anyone sharing my data in the wrong way.
6. The Health Information Network will keep track of who views my health records to make sure they are secure. I can ask my doctor or the Health Information Network for a list of who has looked at my records.

I also understand and agree that:

1. Using my health information for marketing or advertising purposes, or to determine insurance or employment eligibility is strictly prohibited.
2. My consent will remain in effect until the day I cancel my account by "Opting Out" or the Health Information Network no longer exists, whichever comes first. If I suspect or learn that my health information was accessed in the wrong way, I can find information at the follow state website.
    - Oklahoma http://coordinatedcarehn.com/
3. My consent to join the Health Information Network is voluntary.
4. This form replaces all previous Health Information Network consent and opt-out forms I have completed before today.
5. I may ask for a copy of this form after I sign it.

By signing this form, I give all Health Information network participating providers the right to share all of my health records, including sensitive data, through the Health Information Network's network for purposes of providing care to me.

My Name (print please)	My Date of Birth
My Address / City / State / Zip Code	
My or My Legal Representative's Signature*	Date of Signature
Printed Name of Legal Representative (If applicable)	Relationship of Legal Representative (If applicable)

**If I am the parent or guardian of a child, I can consent on behalf of the child only until he or she turns 18. At that time, the child will be automatically opted out unless he or she chooses to join the Health Information Network.*

Aspen Women's Center
Dr. Michelle Brunnabend & Dr. Ronald Brunnabend II
13900 Quailbrook Drive
Oklahoma City, OK 73134
T: (833)277-3692
F: (405)422-9767

"No Show" and "Cancellation" Policy & Procedure
For Office Visits and Procedures

At Aspen Women's Center, our goal is to provide quality obstetric and gynecological care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of obstetric or gynecological care. The following policy is with regard to patients who fail to keep their scheduled office visit appointment or procedure appointment. Please be courteous and call Aspen Women's Center promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely obstetric or gynecological care.

- Patients who fail to show for their scheduled office visit appointment or did not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show/Cancellation" fee of $25.00. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.

- Patients who fail to show for their scheduled office procedure appointment or did not notify the office within 48 hours of their scheduled appointment time, shall be subject to a "No Show/Cancellation" fee of $150.00.

- If scheduled appointment is cancelled by the physician as a medical necessity or other physician related cancellation, then the patient is not subject to this charge. Insurance authorization denials are also an exemption of the fees.

*****These fees are not covered by insurance and will therefore be the sole responsibility of the patient.*****

How to Cancel Your Appointment: To cancel or reschedule appointments, please call Aspen Women's Center at (833)277-3692. If you have any problems getting through, you can leave a voice message or email us at staff@aspenwomenscenterokc.com with your name, appointment date and cancellation reason or request for rescheduling.

I have read and understand the "No Show" and "Cancellation" Policy & Procedure and agree to its terms.

Patient Signature	Date
Patient Printed Name	Date