

WEST DES MOINES OB/GYN ASSOCIATES, P.C.

4949 Westown Parkway, Suite 140 • West Des Moines • IA • 50266 • (515) 223-5466

HIPAA

1) ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of West Des Moines OB/GYN Associates, P.C.s' Notice of Privacy Practices. By signing below I am only giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

X

Name of Patient/Guardian (Type/Print)

Signature of Patient/Guardian

Date

2) AUTHORIZED METHODS OF COMMUNICATION (will be used only if marked)

Detailed phone messages on my
HOME answering machine.

Detailed phone messages on my
CELL phone.

Detailed phone messages on my
WORK voice mail.

I have these special instructions for communication of my health records.

3) AUTHORIZATION TO DISCLOSE PHI (Protected Health Information)

I authorize West Des Moines OB/GYN Associates, P.C. to speak to the following designated individuals regarding my health information as deemed necessary:

Spouse: _____

NO AUTHORIZATION

Relative/Friend: _____

Other: _____

Expiration Date of Authorization of Disclosure of PHI

This authorization is effective (check one): through ___/___/___ or **NO Expiration** unless revoked or terminated by the patient or the patient's personal representative.

X

Name of Patient/Guardian (Type/Print)

Signature of Patient/Guardian

Date

4) FINANCIAL POLICY

I have read and understand the West Des Moines OB/GYN Associates, P.C. financial policy. I agree to assign insurance benefits to West Des Moines OB/GYN Associates, P.C. whenever applicable. I also agree I will be responsible for fees not covered by insurance.

X

Name of Patient/Guardian (Type/Print)

Signature of Patient/Guardian

Date

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the Authorization of Disclosure of PHI.