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.

#____________________

3) CHAPERONE CONSENT FOR SENSITIVE EXAMINATION

❐ Opt Out for a chaperone to be present during my ob/gyn exam(s).

❐ **NO Expiration**

❐ Opt In for a chaperone to be present during my ob/gyn exam(s).

❐ **NO Expiration**

X

Name of Patient/Guardian (Type/Print) Signature of Patient/Guardian Date

4) 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/Relative/Friend:____

Other:____ ❐ **NO AUTHORIZATION**

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

5) 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.