

GENERAL INFORMATION

HOURS

Our office is open from 8:30-5:00 pm from Monday through Thursday and from 8:30 to 11:30 on Fridays. For urgent matters and emergencies, we are always available after hours by dialing our regular office number.

APPOINTMENTS

We pride ourselves in being able to see our patients quickly. If there is an urgent problem, we will do our best to see you the same day or the same week.

We ask that if you need to change your appointment time, we prefer a 24 hour notice so that may offer that appointment time to another patient.

PRESCRIPTIONS

We ask that you call for prescription refills during regular office hours because the on-call physician will not be able to refill prescriptions for you.

FINANCIAL

If you have insurance, you will be responsible only for that portion of the bill that your insurance indicated belongs to you.

Copayments are due at the time of your visit.

If we do not participate with your insurance, any additional balances due after receipt of the insurance payment will be bill to you. It is your responsibility to understand the coverage benefits in your contract.

If payment is not received or financial arrangements are not made, the balance will be forwarded to a collection agency. Any fees incurred during that process will be your responsibility.

It is your responsibility to inform our office of any change in your insurance coverage.

Payments options: We accept cash, check, Master Card and Visa.

Special arrangements may be made in case of financial hardship through our billing representative.

Our fees are based on the usual and customary fees charged in this area.

I have read and understood the above information and agree to the terms outlined above.

Patient Signature: _____

Date: _____

Patient Name: _____

Patient DOB: _____

Patient's Representative's Signature and Name: _____

If patient is unable to sign or is a minor, please sign as authorized person and indicate relationship to patient.

PRIVACY/HIPAA

Acknowledgment of Receipt of Privacy Notice and Release of Protected Health Information.

I have been presented with a copy of Albany Obstetrics and Gynecology's Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request that the following be adhered to regarding my Protected Health Information.

Patient Name: _____

Date of Birth _____

I **DO** want the following individual(s) to have access to the information checked below including family members (please mark all that apply):

Individual(s)' Names: _____

	YES	NO
All information		
Financial Information		
Employer Name		
Office Notes		
Prescription Information		
House phone number		
Office Phone number		
Cell Phone number		
Test Results		
Spouse's name		
Appointment Information		

I wish to be contacted in the following manner (please mark all that apply):

	YES	NO
Home phone with detailed message		
Home phone with call back number		
Cell phone with detailed message		
Cell phone with call back number		
Work phone with detailed message		
Work phone with call back number		
Email with detailed message		
Written message mailed to home		
Written message to be faxed upon request		

I understand as part of healthcare operations, treatment and for payment, that it may become necessary to disclose my protected health information to another entity and I consent to such disclosures including disclosure via fax.

Signature: _____ Date: _____