Esprit Woman Care
9397 Crown Crest Blvd, Suite 320
Parker, Colorado 80138
Phone (303) 766-0197
Fax (303) 841-1943

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Patient Responsibilities

PATIENT NAME: _____

I, the undersigned, in consideration for services being rendered to the patient by Esprit Woman Care, understand and agree to the following:

1. I understand that payment for charges, including co-payments, deductibles, and coinsurance amounts are due by the date of service.
2. I hereby authorize Esprit Woman Care to file with my insurance carrier and I assign payment of medical benefits to Esprit Woman Care.
3. I will keep my account current as to charges for which I am responsible, in the event that I fail to pay charges, Esprit Woman Care is entitled to take whatever action is necessary to collect such charges and I will be responsible for reasonable attorney fees and costs incurred as a result of such collection.
4. I authorize release of any and all medical records and information necessary for continuation of care and for processing any claims associated with services I receive in this office.
5. I understand that my insurance benefits and referral requirements are my responsibility. Esprit Woman Care will assist me in any area possible, but ultimately, I am responsible to understand my benefits and obtain any referrals necessary.
6. I will be sure to inform Esprit Woman Care anytime my personal information or insurance coverage has changed.

My signature below indicates I agree to the terms set above.

✘_____ _____
Patient or Personal Representative Signature* Date

*If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Consent for Use and Disclosure of Health Information

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices (see next page) before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read the following Notice of Privacy Practices carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change these practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by Contacting:

Contact Officer: Julia Artus
Telephone: 303-766-0197 Fax: 303-841-1943
Address: 9397 Crown Crest Blvd, #320
Parker, CO 80138

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

PATIENT / PERSONAL REPRESENTATIVE SIGNATURE:

I, _____, have had full opportunity to read and consider both the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

✘_____ _____
Patient or Personal Representative Signature* Date

*If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____