PARKWEST WOMEN'S SPECIALISTS

9314 Parkwest Blvd. | Ste. 100 | Knoxville, TN 37923
O: (865) 690-7677 | F: (865) 690-7327

Authorization Form (must be completed yearly)

Patient Name ____ **DOB**___________________

Please initial each statement as acknowledgement and agreement then please sign below:

_________ **Assignment of Benefits:** I agree that in consideration of services to be rendered, I assume financial responsibility and agree to pay upon demand to Parkwest Women's Specialists all charges for such services and incidentals incurred. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses. Even though insurance may be filed, I understand that all bills are payable upon receipt and that I, and not the insurance company, am responsible for the payment of all services. I understand if I do not provide a VALID insurance card before services are provided, I will be held financially responsible for all services rendered.

_________ **Assignment of Insurance Benefits:** I authorize the release of any medical information necessary to process any medical claims for services I have incurred. I further authorize all medical insurance payments to be paid directly to Parkwest Women's Specialists.

_________ **Acknowledgment of Receipt of Privacy Notice:** I acknowledge being given an opportunity to receive and review a copy of Parkwest Women's Specialists Notice of Privacy Practices. I consent the use of my protected health information as described in the Notice for Treatment, Payment and Healthcare operations. I understand that I must provide a separate authorization before other disclosures be made.

_________ **HIV Waiver:** In the unlikely even that an employee of Parkwest Women's Specialist or the Phlebotomist is stuck with a contaminated needle, I give permission for Parkwest Women's Specialists and LabCorp permission to submit a blood sample for HIV testing.

_________ **Change in Insurance Responsibility:** I understand that I, the patient, am responsible for letting Parkwest Women's Specialists know of any changes in my insurance carrier/policy. If I do not make these changes known willingly and before my visit, and Parkwest Women's Specialists is not in network with my new/additional carrier, I am responsible for paying all services rendered and I will be dismissed from the Practice by formal letter.

Authorization for Release: I give permission for Parkwest Women's Specialists to discuss information regarding my medical and/or financial information with the following people if I am not available or not otherwise able to take the information myself:

Patient Only Phone #__________________________

Other Name______________________ Relationship_________________ Phone #____________________

Other Name______________________ Relationship_________________ Phone #____________________

_________ **Voice Call Communication:** I understand that the office may need to call me for appointment reminders or notify me of test results. I give permission for Parkwest Women's Specialists and Staff to call; I understand they will identify themselves when leaving messages on my phone or with anyone answering my home/cell phone when trying to reach me. (We will not leave test results on your messaging system, only identify ourselves and ask for a return call).

I give you permission to contact me and leave messages at Phone # ____________________________________

____ ______________________

Patient Name **Date**