PREMIER WOMEN'S HEALTH, LLC

NAME DATE

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand and authorize my medical information to be released to Premier Women's Health from:

_____

_____

This information is to be released to:

PREMIER WOMEN'S HEALTH
DR. CAROLYN KOLLAR
1758 BROAD PARK CIRCLE SOUTH
MANSFIELD, TEXAS 76063
FAX (972) 780-7385

I understand that the information is to be release for the following purposes (mark all that apply):

___TREATMENT ___REFERRAL ___CO-MANAGEMENT ___CONTINUITY OF CARE

___RECORD REVIEW ___PATIENT REQUEST ___OTHER: _____

Information to be requested from the following time period:

From: _____ (month/year) To: _____ (month/year)

I hereby authorize Premier Women's Health to use/disclose my protected health information in accordance with the current Health Insurance Portability and Accountability Act (HIPAA) guidelines. I understand that I may be responsible for any processing fee that may be required for the requested information. Identification will be required for patient privacy and confidentiality. I understand that my medical information may include sensitive health information. I understand that I may revoke this authorization in writing at any time. I understand that this authorization expires 180 days from that date of my signature. A photocopy of this authorization is considered as valid as the original. I understand that if the recipient authorized to receive that health information is not a health plan or healthcare provider the released information may no longer be protected by federal and state privacy regulations.

_____

Signature of Patient or Legal Representative Date

_____

If Representative, specify relationship to patient Date

*** * * If more than 10 pages, please mail the records to our office. * * ***

PREMIER WOMEN'S HEALTH, LLC

NAME DATE

OFFICE POLICIES & PRIVACY PRACTICES

APPOINTMENTS

Office visits are by appointment only. We strive to see our patients as close to their appointment times as possible. As you know, emergencies do arise and can cause an increase in wait time. We understand that there are times when it will be necessary for you to cancel or reschedule your appointment. In order for us to be available to as many patients as needed, we ask that you kindly provide our office with a 24 hour notice. Our office will give you a reminder call within 5-7 day of your appointment:

- There will be a $50 fee for a no-show appointment or a non-emergent cancellation the same day of your appointment or less than 24 hours before your appointment.

- There will be a $75 fee for a no-show for a cancellation the same day of a scheduled procedure, including aesthetics treatment, or less than 24 hours before your scheduled procedure or aesthetics treatments.

- There will be a $200 fee for a cancellation of a surgical procedure less than 72 hour before your surgery.

These fees are billed directly to you and must be paid before your next scheduled appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

TELEPHONE CALLS, MEDICATION REFILLS AND TEST RESULTS

We ask that you make all non-emergent calls and prescription refills during our regular office hours. Calls made after 4 pm may not be returned until the next business day. Please allow 5-7 days to process prescription refills and/or requests. **Please allow 14 days to receive calls reguarding your results pending provider's review.**

REFERRALS

Allow 5 to 7 business days to process routine referrals.

NSF/CLOSED ACCOUNTS

There is a $50 charge for all returned checks.

PATIENT / INSURANCE PAYMENTS

Payment is expected at the time services are rendered. Payment will be accepted in the form of cash, check, Visa, MasterCard, or Discover. There is a 3.5% fee added to any payment taken with a card. We require that you update your information annually or as often as the information changes to assure you receive correspondence from our office. Please be aware that most insurance plans do not cover 100% of the services provided. Account balance exceeding 90 days will be turned over to an outside collection agency and your care will be terminated with our practice.

MEDICAL RECORDS / FMLA

All medical record requests require written release of information. Please allow two weeks for the processing of all medical records. There is a $25 fee for the 1st 25 pages and $0.50 per additional page patient fee for medical record requests. This must be paid prior to disbursement of records.

There is a $35 initial fee for forms requiring completion by your provider and a $15 fee for additional forms for the same encounter. This includes Family Medical Leave, Disability, etc. Please allow two weeks for completion of all forms.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

I have read and understand the office policies related to care provided by Premier Women's Health, LLC

(CONTINUED)

PREMIER WOMEN'S HEALTH, LLC

NAME DATE

OFFICE POLICIES & PRIVACY PRACTICES, CONT.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

These policies are to provide a description of the uses and disclosures of certain health information. I understand that Premier Women's Health, LLC reserves the right to change its Notice of Privacy Practices, Patient Financial Policy and Office Policy. Prior to implementation an updated copy will be provided at the office. A copy of the updated Policies may be requested by calling the physician's office or requesting a copy in person at an appointment.

Patient Signature/ Legal Representative Signature Date

ACKNOWLEDGMENT OF RECEIPT OF CELLULAR PHONE DISCLOSURE

I authorize Premier Women's Health, LLC to contact me via current and any future phone number (s), email addresses, or wireless device(s) regarding my delinquent account(s) I owe to Premier Women's Health, LLC or to receive general information from Premier Women's Health. I also authorize its agents, representatives and attorneys (including collection agencies) to use automated telephone dialing equipment and artificial or pre-recorded voice messages and personal calls in their effort to contact me for purposes of collecting any portion of my account which is past due. I understand that I may withdraw my consent to call my cellular phone by submitting my request in writing to Premier Women's Health, LLC or its agents.

I have read this disclosure and agree to the terms described above.

Patient Signature/ Legal Representative Signature Date

PREMIER WOMEN'S HEALTH, LLC

NAME DATE

HIPAA PRIVACY COMMUNICATION

In complying with Health Insurance Portability and Accountability Act, HIPAA, we want to make sure that we safeguard your personal infomation according to your wishes when it comes to family, friends and co-workers.

Please answer the following questions and indicate with a circle your choice:

YES / NO May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regularly answers your calls?

YES / NO May we leave messages on your answering machine at home?

YES / NO May we leave messages on your cell phone voicemail?

YES / NO May we leave messages on your voicemail at work?

YES / NO May we discuss your appointment schedules with your spouse/partner/parent?

YES / NO May we send text messages to your cellphone?

Please list any other persons other than yourself that you would permit us to discuss your medical care or financial responsibility with upon request.

1) Name: _____Relationship: _____Phone:_____

MEDICAL CARE / FINANCIAL RESPONSIBILITY / BOTH

2) Name: _____Relationship: _____Phone:_____

MEDICAL CARE / FINANCIAL RESPONSIBILITY / BOTH

You must inform us, IN WRITING, of any changes in your directives. This will be kept in your file along with your acknowledgment of receipt of our Notice of Privacy Practices.

_____

Printed Name Signature Date

*** * * Please provide a contact number for which detailed voice/ text messages may be left * * ***

_____ _____

Phone Number Email

PREMIER WOMEN'S HEALTH, LLC

NAME DATE

CONSENT FOR TREATMENTS

CONSENT TO TREAT

By signing this consent, I am authorizing my physician and/or other individuals she deems appropriate to perform and/or order exams, tests, procedures and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Premier Women's Health unless revoked by me verbally or in writing.

Patient/ Legal Representative Signature Date

WELL WOMAN EXAM CONSENT

The American College of Obstetricians and Gynecologists explains the need for an annual assessment as a fundamental part of medical care to promote prevention practices recognize risk factors for disease, identify medical problems and establish the clinician-patient relationship. The annual health assessment should include screening, evaluation, counseling and immunizations based on age and risk factors. Performance of a physical examination is a key part of an annual health assessment visit. The components of that examination may depend on age, risk factors and physician preference.

Every insurance plan has different stipulations and/or guidelines that must be met. Premier Women's Health, LLC leaves the responsibility to you as the patient to understand what your insurance will and will not cover for your annual well woman exam. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services. As your physician, I believe that certain services are an important part of your medial care and recommend that you receive these services as part of your current treatment plan. However, in the event the services are not considered to be covered benefits under your health insurance you will be personally responsible for the payment of such services. The purpose of this notice is to help you make and informed choice about whether or not you want to receive these items or services that may or may not be covered by your health insurance.

Patient/ Legal Representative Signature Date

NON-COVERED SERVICES

I acknowledge that I have been informed in advance of receiving services at Premier Women's Health that may or may not be covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges.

Patient/ Legal Representative Signature Date

Relationship to Patient

*** * * This form must be signed by the patient or legal guardian *PRIOR* to receiving any services. * * ***