Patients' rights and responsibilities

At Best Choice OB/GYN, we hope to make your office visit as comfortable as possible. We have condensed the information on this form. If you would like a copy of this signed consent form, please request one with the receptionist.

Patient's rights:

● Patients are treated with respect, consideration, and dignity. We follow the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Under HIPAA, patients have the right to privacy of information.

● Patients have the right to:

➢ Know the qualifications of their physician and who is responsible for coordination of care

➢ Know complete information regarding diagnosis, treatment, and prognosis. If patient is medically inadvisable, then the information is provided to a legally authorized person

➢ Refuse treatment and be informed of the consequences of those actions

➢ Seek another medical opinion

➢ Get Information concerning the hospitals should a transfer/emergency occur. The hospitals to which the patient is transferred to will have given prior approval.

Patient's responsibilities: (**Please write your initials on the line, beside each statement**)

____ I understand that it is my responsibility to read and comprehend all permits and/or consents that I sign. If I do not understand, it is my responsibility to ask for clarification.

____ I understand that it is my responsibility to answer all medical questions truthfully to the best of my knowledge, read, and follow instructions given by the physician and to contact the physician if there are any complications.

____ I understand that it is my responsibility to check plan benefits with my health insurance company. Any applicable co-payments, deductibles, or co-insurance will be requested. If I do not have insurance, I will be considered self-pay and I will honor that payment in full. I understand that any amounts not covered by my health insurance company will be my legal responsibility. I accept to *charge to my credit card if there is uncovered portion from my health insurance company such as deductibles, co-insurance, copayment based on the EOB (explanation of benefits). My Credit card information: Visa, Master, Discover, American express

Credit Card Number: Expiration:

Security Digits: Billing Zip Code:

*3% credit card processing fee will be charged.

Office Policy

Test reports and paperwork:

- Test reports will be released only to the patient.
- To complete all paperwork such as disability form takes 2 weeks for processing.

Medical records:

- All medical records that need to be transmitted to another provider require a consent for medical record release form signed by the patient or patient's legal guardian. It is required a 2-week advanced notice. There will be no charge for the transmission of medical records to another provider.
- All medical records that need to be picked up by patient, a 2- week advanced notice is required and a $20 fee will be charged.

Cancellation: We understand that unexpected events come up, but we would appreciate it if you could give us a 24-hour notice in advance. If you cancel less than 24 hours before your appointment time, you will be considered a late cancellation. If you do not call to inform us and do not show up, you will be considered a "no-show." Late cancellations and no-shows are subject to a $20 fee, which will be charged at the next visit.

Lateness: If you are running late, please inform us beforehand. We will allow a grace period of 30 minutes. However, if you are late and do not call, a $20 charge will be charged.

I, _____, (Date of Birth: _____), have read and acknowledge my rights, responsibilities and the office policy as described above.

_____ _____

Signature Date

If the patient is under 18 years old, I, as the legal guardian/parent, consent to the doctor treating my child, _____. I have read the above rights, responsibilities and the office policy. I understand that I am accountable for the above responsibilities.

_____ _____

Signature of legal guardian/parent Printed name of legal guardian/parent