Athens Women's Clinic
817 Cook Drive
Athens, TN 37303
Phone: (423) 745-3394 Fax: (423) 745-6779

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to review the Notice of Privacy Practices. I understand that the Notice describes how my protected medical information may be used, disclosed, and how I may get access to this information. I have also been offered a copy of the Notice for further review.

If the facility needs to contact me to discuss my protected health information (i.e. lab results or billing issues), you may either leave a message or discuss the information with the following individual(s):

	Name	Relationship	Phone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

By signing below, I agree to the above statements

X_____ _____
(Patient must sign, regardless of age) Date

AUTHORIZATION AND ASSIGNMENT

Please remember that insurance is considered a method of reimbursement of service for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any amount owed towards your deductible, co-insurance, or other balances not paid for by your insurance. In order to control the cost of billing, we request that your charges for an office visit be paid by cash, check, or credit card at the time of service.

I authorize Athens Women's Clinic to release any information acquired by my physician and / or staff to my insurance carrier(s). I authorize payments to be made directly to my physician. I recognize and accept responsibility for any balance or fees not covered by insurance and agree to pay the balance in a prompt manner. In the event this account is referred to an outside agency, credit reporting bureau, or attorney for collection, I agree to pay all attorney fees, collection costs, court costs, and / or any other expenses incurred in the collections process according to the 1989 statutes of the State of Tennessee.

X_____ _____
Patient or Guardian signature Date