

PATIENT UNDERSTANDING OF CARE

Thank you for choosing Minnesota Gynecology & Surgery, LLC, as your healthcare provider. The following is a statement of our clinic policy. All patients MUST complete this form before seeing their physician. Please initial paragraphs 1-6 below to indicate your understanding and consent. Please pay close attention to number 3 and ask if you have any questions.

1. CONSENT OF TREATMENT: After being informed, and with my consent, I authorize the performance of diagnostic tests, procedures and treatments, and/or the administration of medications, which may be deemed appropriate by my physician or other personnel involved in my care.

2. RELEASE OF INFORMATION: I hereby authorize Minnesota Gynecology and Surgery, LLC, to disclose any information about me gathered during my visit with Minnesota Gynecology and Surgery, LLC, provider, including any medical and billing information, to my referring doctor or insurance company as may be necessary for the payment of my bill, determination of my benefits, quality review purposes or ongoing care.

3. ASSIGNMENT OF BENEFITS: I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize payment of medical benefits to Minnesota Gynecology and Surgery, LLC, for services rendered to me. I understand this assignment is to remain in effect until revoked by me in writing. I also understand that a photocopy of this assignment is to be considered as valid as an original.

(Please remember that insurance contracts are a relationship between you and your insurance company. Often, insurances does not provide full payment of medical costs. Payment of this bill is, therefore, your responsibility. If Minnesota Gynecology and Surgery, LLC, holds a contract with your insurance company, we will bill your insurance company on your behalf, provided you have given us all your current insurance company information at the time of your visit. In this case, you assign to Minnesota Gynecology and Surgery, LLC, all benefits payable directly to us for services rendered to you. If Minnesota Gynecology and Surgery, LLC, does not hold a contract with your insurance company, we will provide to you an itemized statement of services rendered to you to send to your insurance company for payment directly to you.)

4. I request the payment of authorized Medicare benefits be made to me or on my behalf to Minnesota Gynecology and Surgery, LLC, for any services furnished to me by the physician/clinic/supervisor. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

5. USUAL AND CUSTOMARY FEES: Minnesota Gynecology & Surgery, is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. I understand that I am responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees.

6. Minnesota Gynecology and Surgery, LLC, LIABILITY FOR PERSONAL PROPERTY: I understand that this health care facility will not be responsible or liable for loss or damage to any patient money, jewelry, or other personal property which are worn by the patient or kept in the patient or kept in the patient's exam room.

Date: _____ Signature: _____ (Patient or Responsible Party/Relationship)

Please initial and date for each year: _____