

NOTICES & AUTHORIZATIONS

A broken appointment affects many people. For your next visit, if you are not able to keep your scheduled appointment, please call to reschedule at least a minimum of 24 hours in advance, or a \$25.00 fee may apply.

**We are available for after hour emergencies by dialing (978) 475- 2731
Non-Emergent matters will be handled on the next business day.**

Our office no longer notifies you of any normal results.
Please be sure we have your current contact phone numbers in order to reach you if necessary.

Your co-pay is due at the time of service.
If you are not able to provide your office co-pay at the time of service, our office will charge your account an additional administrative fee of \$15.00.

Our office uses multiple labs companies of Quest, Lab Corp. and Lawrence General to process your specimens. These specimens may be sent out of our office for processing. Please notify us if your insurance requires you to use a specific lab other than listed to process your specimen so that we may comply with your known healthcare benefits.

I authorize the release of medical information necessary to process medical benefits and I authorize payment of medical benefits to Andover

Annual services by the office.

Due to the new Health Care Reform Law passed August 1, 2012, Preventative/Annual services do not warrant a copay. If we should address a health concern or aid you in another matter not related to your annual exam, your insurance will be billed accordingly and may need a copay to be paid. If at such time we are made aware that a copay is needed, our office will bill you directly.

Patient Portal

Our confidential patient portal is available for patients who sign up at our office with valid email address. Once you receive our welcome invitation to join our patient portal you will be given a temporary password to successfully register in our patient portal. On our patient portal you may contact our office at any time and review non-sensitive test results. [HTTPS://HEALTH.ECLINICALWORKS.COM/ANDOVEROBYGN](https://health.eclinicalworks.com/andoverobgyn)

HIPAA Notice of Patient Privacy Practices

The Andover OB/GYN, P.C. practice privacy notice is posted in every office to review.
I may request an additional copy of the privacy notice at any time.

Permission to Communicate with Your Primary Care Physician, Other Community Care Providers and/or Mental Health Providers:

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician and other community care providers including mental health providers, and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care. Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician, Health Insurance Company and/or mental health providers.

Consent for RX Hub Inquiry

I hereby provide my consent for Andover OB/GYN, P.C. to obtain my Rx History using the SureScripts-RxHub network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to-system communications.

Notice

I acknowledge having received a copy of Andover OB/GYN's notices and authorizations including HIPAA. I may request a personal copy at any time. My signature below is my expressed consent for Andover OB/GYN to communicate with third party payers, outside providers and to acquire RX Hub inquiries on my behalf.

Insurance Waiver

By signing this form I understand that the cost of services rendered at any of our offices will be my responsibility if for any reason my insurance company denies services.

Signed _____ Date: _____

Printed Name: _____