# THE WOMEN'S HEALTH ASSOCIATES GROUP, LLC

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## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, & OPERATIONS (TPO)

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I **consent** to the use and sharing of my health records for treatment, payment, and operation (TPO) purposes as described in the Notice of Privacy Practices. **I know that if I do not consent, you cannot provide medical services to me.**

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES –** A detail of your rights and how your medical information will be used and disclosed in our NOTICE OF PRIVACY PRACTICES.

I understand and agree that I am financially responsible for the balance on my account for all professional services rendered. If I do not have insurance coverage, I will be responsible for payment in full at the time of service. I understand that if my account is delinquent, I am responsible for any collection fees and attorney fees associated with my outstanding delinquent balance.

This authorization shall remain valid until I, the patient/guardian, revoke the said authorization through written notification.

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES.

Print Full Name: ______________________________________________
Patient or Legal Representative

Signature: ____________________________________________________
Patient or Legal Representative

Date of Birth: _______________________

*For office use only:*

Witness Signature: ____________________________________________

Date: _______________________