

Complete Women's Care

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Consent Form

1. I understand that under the Health Insurance Portability and Accountability Act I have certain rights to privacy regarding health information. I have read the Privacy Practice notification provided. **Initials:** _____
2. I authorize Complete Women's Care office to leave messages via my answering machine for appointments, reminders, general medical information, test results, billing, and/or referral information. **Initials:** _____
3. I authorize Complete Women's Care to communicate verbally with _____
_____ regarding my appointments, test results, general medical information, or referral information. For information for identification _____'s SS# is _____ . **Initials:** _____
4. I authorize Complete Women's Care to release any medical information needed to determine payment for my services. **Initials:** _____
5. I authorize Complete Women's Care to release protected health information to only HIPPA covered entities (health plans, providers, and healthcare clearinghouses) on my behalf. **Initials:** _____
6. I authorize my insurance carrier to make direct payments on my behalf to Complete Women's Care for medical services furnished. **Initials:** _____
7. I am aware I am responsible for co-payments, co-insurance, or any deductible at the time of services. **Initials:** _____
8. Authorization is valid until rescinded by me in writing. **Initials:** _____

Patient's Name: _____ SS#: _____

Signature: _____ Date _____

Relationship to patient (if pt is a minor or unable to sign): _____