Friendswood Women

Obstetrics & Gynecology
Encounter Record

AUTHORIZATION FOR TREATMENT

I hereby grant permission to authorize and direct the authorities of Amber Shamburger, MD to perform such medical and/or surgical procedures on me as they deem in their judgment advisable or necessary for the treatment or care of (1) any condition now recognized or contemplated, and (2) any conditions, not now recognized or contemplated, which are revealed or arise during the course of such treatment or care. In the event that I do not agree with my treatment plan, I will advise Amber Shamburger, MD as soon as decided upon by (1) notification in person in the office or (2) by certified mail. I understand that if I do not comply with the advised treatment plan recommended by Amber Shamburger, M.D. which results in my health being put at risk, I may be released from the care and responsibility of Amber Shamburger, M.D. In the event that may care is terminated due to non-compliance on my part, I understand that I am responsible for signing a records release form in the office of Amber Shamburger, M.D. and for finding other medical care.

ASSIGNMENT OF BENEFITS

I certify that the information given by me is true and correct to the best of my knowledge and promise to pay Amber Shamburger, M.D. all charges due by me as assigned by my insurance company. I authorize Amber Shamburger, M.D. to send photocopies of any and all of my personal and medical records to my insurance company in order to process my claim if requested. I authorize my insurance company to send payment directly to Amber Shamburger, M.D. If payment is sent to me from my insurance carrier, I understand that I am responsible for forwarding all applicable payments due to Amber Shamburger, M.D. within 10 business days of receiving the payment. I understand that failure to do so will result in legal action being filed against me by Amber Shamburger, M.D. and possibly my insurance carrier. I understand that it is a federal offense to tamper with any insurance payments that are incorrectly sent to me. I understand that it is a federal offense to falsify any information in order to have a claim paid by my insurance carrier on my behalf.

TREATMENT OF A MINOR

Minor: A minor is defined as an individual under 18 years of age that is not married nor self-supporting.
Emancipated minor: A minor under 18 years of age that is not under the specific care of a legal guardian either because they have married or for other legal reasons.
As defined by Texas State Law, doctors may notify or involve legal guardians of care provided in our office except in the case of an emancipated minor. Minors may make certain decisions in their medical care, but it varies depending on the situation. Doctors may, however, notify the legal guardian without the minor's consent in the event that the doctor feels the minor's health is being jeopardized by non-compliance of care. Doctors may also speak directly with the legal guardian if the minor is mentally disabled and/or unable to speak or comprehend verbal communication.

For more details, visit: www.cms.gov

Date form signed:
Printed name of patient: **DOB:**
Signature of patient/legal guardian: **Relationship:**
Printed name of legal guardian (if applicable):

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Obstetrics & Gynecology
Privacy Policy

Our primary goal is to provide you with quality healthcare that consists of accuracy, efficiency, and compassion. In addition to your health, we acknowledge that protecting your private, personal information is our obligation and we are committed to doing so on every level. We create an electronic record, or a "patient chart", that contains the descriptions of the care, services, and correspondence you give or receive through our office. This record is required in order to provide you with accurate, quality care in addition to complying with certain legal requirements. The original copy of your chart and/or electronic record is the property of Amber Shamburger, MD. You may request your records to be transferred by completing a medical records release form. As allowed by Texas state law, there will be a fee for providing you this service. We require15 business days from the date of your request to prepare and send your records unless the records are for urgent or life threatening health issues.

In certain circumstances, your records may be released without prior written/verbal authorization as allowed by law. Some examples are:

1. To your insurance company in order to pay your medical claim.

2. To hospitals, clinics, outpatient facilities, and/or doctor's that you are currently seeing unless you notify us in advance in writing not to do so.

3. To any emergency provider/facility that would need to know your medical history in the event of a life-threatening emergency.

4. To a court-appointed judge or law enforcement official who has a notarized subpoena and/or warrant.

We do participate in e-prescribing and are able to access all prescriptions purchased through your insurance company. <u>Please inform us if you do not want this information to be accessed.</u>

No medical information is released to your financial institution when you pay by check, credit card, etc. The only personal information that is transmitted is your name, date, and amount of the transaction. You authorized the release of this information when you opened your account with your financial institution (refer to your terms and agreements statement provided by your financial institution.)

You have the right to file a written complaint if you feel that your information has been violated. We have complaint forms here in our office that you may fill out and forward to the appropriate agencies. If you feel that your information has been violated, please ask to speak with the office manager.

We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We also have the right to make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

We are required to follow certain federal guidelines and laws regarding the confidentiality of your personal health information. One of these prevents us from discussing anything in your medical file with anyone other than yourself or other medical personnel involved in your care. If you would like us to discuss lab results or other personal information with your significant other, family members, or any other individuals, please fill in their name and relationship to you in the section listed below.

Name of individual Relationship to you

1.
2.
3.

**If you need to add more names, please let us know at the time of your visit.

I HAVE READ AND COMPLETELY UNDERSTAND THIS PRIVACY POLICY. I UNDERSTAND THAT I AM RESPONSIBLE FOR NOTIFYING DR.SHAMBURGER'S OFFICE STAFF OF ANY CHANGES OR UPDATES TO THIS RECORD.

******If the patient is a minor, the legal guardian is automatically appointed by law to provide/receive protected information on behalf of the patient.***

SIGNATURE OF PATIENT/LEGAL GUARDIAN PRINT NAME DATE SIGNED

FOR COMPLETE, DETAILED INFORMATION REGARDING PRIVACY LAWS, VISIT: www.cms.gov/hipaa

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Obstetrics & Gynecology

EMAIL ADDRESS FORM

Date completed:
Patient name (print):
Date of birth:
EMAIL ADDRESS:

❖ **ANY AND ALL EMAILS ARE FOR INFORMATIONAL PURPOSES ONLY. PLEASE DO NOT RESPOND TO OUR EMAILS AS WE WILL NOT REPLY TO THEM. ANY QUESTIONS OR COMMENTS MUST BE MADE BY CALLING OUR OFFICE AT 281-992-5914.**

❖ You are responsible for providing us with a private, secure email address. If you do not want your information viewed by anyone else, you must make sure that no one else can access your email. We cannot be held responsible for who views your email once we have submitted it to the address you provided. By providing your email address, we assume that you are giving us consent to email you at anytime. ***We recommend that you do not use your work email address because your employer may be able to view your emails.***

❖ Any email sent to you will be for informational purposes only. No private, detailed health information will be included in any emails. For example: We may notify you that your lab work or Pap smear was normal, but we will not include the detailed results. We may also send you an email notifying you of any office policy changes, rescheduled appointments, questions/comments about your insurance, etc. If any of your testing requires additional attention due to out-of-range or abnormal results, you will be notified via telephone that you must come in for an office consultation. **WE DO NOT PROVIDE CONSULTATIONS OR DETAILED RESULTS OF ABNORMAL LAB RESULTS VIA EMAIL OR BY TELEPHONE. YOU WILL BE REQUIRED TO MAKE AN APPOINTMENT TO DISCUSS THE RESULTS AND YOUR TREATMENT PLAN. IF YOU HAVE A CO-PAY FOR OFFICE VISITS, YOU WILL BE REQUIRED TO PAY AT THE TIME OF SERVICE.**

❖ If your email address changes, you are responsible for notifying us. If you do not update your records with a current email address, you may not receive any information

❖ Any changes to your information must be made in writing. You may mail or fax a letter requesting this change. The letter must include the date of the request, your printed name, your date of birth, and your signature. Please include detailed information regarding the detailed changes of your request.

❖ Your email address will not be used as a contact method if you transfer care to another OB/GYN. If you move or transfer without notifying our office, we may still send you informational emails.

❖ If the patient is a minor, the only acceptable email address that will be used is that of the legal guardian.

My signature certifies that I completely understand the email notification policy. I understand that I am responsible for notifying Dr. Shamburger's office staff of any changes that I request.

Patient/Legal Guardian:

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PAYMENT & COLLECTION POLICY

All payments are to be made payable to Amber Shamburger, MD, PA the practice name.

- There is a charge for every office visit and/or consultation regardless if you are examined or not.
- We do not file with secondary insurance policies for office visits unless you are on Medicare.
- We accept cash, personal checks (processed electronically through TeleCheck), Visa, MasterCard, Discover. We do not accept post-dated checks.
- If you pay by check, your check will be your receipt after we verify funds thru Telecheck. It is processed the same as a checkcard debit from your checking account.
- There is a $25.00 returned check fee for insufficient checks. If the check is not paid within 15 days of the date that is listed on your statement that is mailed to you, the account will be turned over to the Galveston County Sheriff's Department. PLEASE REMEMBER… IT IS AGAINST THE LAW TO WRITE A HOT CHECK!! We will not schedule any future appointments until your balance has been paid in full.
- If you're pregnant, you will be asked to pay any office co-payments applicable at your first visit. We bill for the first visit and again when the baby is born. If you have a co-Insurance that is applied after deductible has been met, you must pay your co-insurance by the 28th week of pregnancy in order to stay as a patient with the practice. For example: you may have a $500.00 deductible to meet and then you pay 20% after you have met your deductible. You will be responsible for paying the 20% of the contracted rate by your 28th week of pregnancy. We do not charge for your deductible because you will meet it with your lab work, ultrasounds, etc. since we only bill at the beginning and end of your pregnancy. If you have a deductible that is applied to your first visit, you will not pay at the time of service. We will bill your insurance company and whatever they apply to your deductible; you must pay upon receipt of your statement. More detailed information will be given to you after your first visit with Dr. Shamburger. Contact Angie for any questions you may have BEFORE your first appointment.
- If you are a self-pay patient (NO INSURANCE), please call our office BEFORE your visit to get an estimate of what you will have to pay after you are seen by Dr. Shamburger. No payment plans are available for office visits. Payment is due at the time services are rendered.
- If you are a self-pay patient (NO INSURANCE) and plan on getting Medicaid, please not that we will not file a retroactive claim. This means that if you pay for your visit and get Medicaid at a later date, we will not file a claim in order to refund your payment. You are responsible for getting reimbursed by Medicaid if you are eligible.
- If your insurance company does not pay your claim because of reasons that can be resolved by you, you will be responsible for getting the requested information to them. This includes filling out paperwork requested by your insurance and/or employer, paying premiums, notifying them of other insurance policies, etc. If the claim is not paid due to lack of information from our office, you will NOT be held responsible. We will correct our mistake and re-file the claim. You will be asked at each and every visit to present your insurance card. This is done to ensure that we have the correct information to file your claim. Even though your insurance company may not change, they frequently change group numbers and claims addresses. The front office staff is required to check the information every visit, so we appreciate your cooperation.
- If you are in a dispute with your insurance company regarding claims that have not been paid, you will still be held responsible for paying your balance within 90 days. You will need to get reimbursed from your insurance company for any payments you make to our office.
- ALL BALANCES PAST 90 DAYS WILL BE SENT TO OUR COLLECTION AGENCY. THIS INFORMATION IS REPORTED ON YOUR CREDIT REPORT. THERE WILL BE A $50.00 COLLECTION AGENCY CHARGE ADDED TO YOUR BALANCE IF WE ARE FORCED TO TURN YOUR ACCOUNT OVER.

BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT YOU COMPLETELY UNDERSTAND THIS POLICY.

PATIENT SIGNATURE PRINT NAME DATE SIGNED