Crown Mountain Women's Health

1298 South Chestatee St.
Dahlonega, GA 30533
(706) 864-3400

Privacy Policy

Use and Disclosure of Your Protected Health Information
Your protected health information (PHI) will be used by Crown Mountain Women's Health or disclosed to others for the purpose of treatment, obtaining payment or supporting the day to day health care operations of the practice.

Notice of Privacy Practice
You should review the Notice of Privacy Practices provided by Crown Mountain Women's Health for a more complete description of how your PHI may be used or disclosed. You have the right to review the Notice of Privacy Practices prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use and disclosure of your PHI. Crown Mountain Women's Health may or may not agree to the restriction. If Crown Mountain Women's Health agrees to your request, the restriction will be binding on the practice. Use or disclosure of your PHI in violation of an agreement will be a violation of the Federal Privacy Standards.

Revocation of Consent
You may revoke this consent at any time. You must do so in writing. Any use or disclosure that has not already occurred prior to the date on which your revocation of consent is received will not be affected.

Crown Mountain Women's Health reserves the right to modify the privacy practices outlined in the notice.

**I have read and consent to the privacy policies

______________________________________ ______________
(Patient Signature) (Date)

Assignment of benefits:
** I hereby assign to Crown Mountain Women's Health any insurance or other third party benefits available to me for healthcare services provided to me. I understand that Crown Mountain Women's Health has the right to refuse or accept assignment of benefits. If these benefits are not assigned to Crown Mountain Women's Health, I agree to forward to Crown Mountain Women's Health all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. This assignment shall remain valid until written notice is given.

______________________________________ ______________
(Patient Signature) (Date)

Authorization for release of information:
**I authorize Crown Mountain Women's Health to release all information requested by my health insurance company, Medicare or other third-party payers. I authorize Crown Mountain Women's Health to release all medical information to my referring physician and my primary care physician. I authorize Crown Mountain Women's Health to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company to release such information to Crown Mountain Women's Health. I agree that these provisions will remain in effect until I provide written revocation to Crown Mountain Women's Health.

______________________________________ ______________
(Patient Signature) (Date)

**I have read and fully understand the financial policy of Crown Mountain Women's Health. (Do not sign until you have seen Linda-Insurance and Billing Administrator)

______________________________________ ______________
(Patient Signature) (Date)