



Statement of Managed Care Responsibility

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines, if you let us know at each time of service exactly what those guidelines are.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered and even more importantly, where those services may be performed.

Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently order services, such as lab work or hospitalization that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for these charges is then your responsibility.

With your cooperation and help, you should be able to receive all the benefits offered to you and we will be able to concentrate on caring for your medical needs.

I authorize Via OB/GYN to release my medical records to my insurance company(s) and to act as my agent in helping me obtain payment from my insurance company(s). I authorize my insurance company(s) to make payment directly to Via OB/GYN. (NOTE: Medicare is a participating provider.) I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR MY BILLING INCLUDING ANY AMOUNT NOT COVERED BY MY INSURANCE (except in case of a contractual agreement between my insurance carrier and my physician). Should collection proceedings become necessary, I understand that I will be responsible for attorney fees, court costs and all collection costs.

I have read and understand the information stated above and agree to accept responsibility as described.

Signature: _____ Date: _____

Receipt of Notice of Privacy Practices

I acknowledge that I have received and read the Community Health Network Notice of Privacy.

Signature: _____ Date: _____

Financial Interest Disclosure

This serves as written notice that Dr. Hayes has a financial interest in North Campus Office Associates, L.P., which has a financial relationship with the Indiana Surgery Center - North. You may choose to be referred to a health care entity other than the Indiana Surgery Center - North for your outpatient surgery.

Signature: _____ Date: _____