



Premier Gynecology INC.

JoAnn Krivetzky, MD, FACOG

CONTEMPORARY HEALTHCARE
FOR TODAY'S WOMAN

Patient's Name: _____ Date Completed: _____

Notice of Privacy Practices for Protected Health Information
Acknowledgement of Receipt of Notice of Privacy Practices

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Signature: _____

Financial Policy

I understand my insurance policy is a contract between my insurance company and myself, and that I am ultimately responsible for the entire bill. I understand that the fees are based on treatment received and have no bearing on outcome. I also understand there may be a charge for appointments missed or cancelled less than 24 hours prior to my appointment time.

Patient signature: _____

Authorization to Pay for Professional Services Rendered

I hereby authorize payment directly to Premier Gynecology, Inc. of the benefits for professional services rendered, otherwise payable to me as determined by my insurance company, but not to exceed the fee as finally determined by the physician. I understand I am financially responsible for any professional charges not paid by my insurance company to Premier Gynecology, Inc.

Patient Signature: _____

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