Women's Clinic of Lincoln, P.C.
220 Lyncrest Drive Lincoln, NE 68510
402-434-3370

Acknowledgement of Receipt of Notice of Privacy Practices and Financial Responsibility for Services Provided

To our patients:
The privacy of your health care information is extremely important to us. We want you to understand how we use and disclose your information and your rights in this information. Our *Notice of Privacy Practices* provides more detailed information about how we may use and disclose your protected health information. You have the right to review our *Notice of Privacy Practices* before you sign this consent. They are located in our lobby or with a receptionist for your review.

We reserve the right to change the terms of our *Notice of Privacy Practices*. You may obtain the current notice by calling our office at (402)434-3370 or asking our receptionist.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or other health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us. This authorization will remain valid until written notice is given, by you, revoking said authorization. (See back side of form)

The undersigned acknowledges that they have read and understand the above information regarding how the Women's Clinic of Lincoln, P.C. may use their protected health information.

Signature_____Date:_____

Print Name of Patient_____DOB_____

If you are signing as the patient's representative:

Print your name:_____Relationship to Patient_____

Consent for Treatment and Financial Responsibility

I consent to medical treatment for myself or for the patient for whom I am the legally authorized representative. I understand that the Providers of the Women's Clinic of Lincoln, P.C. will provide appropriate information about any proposed treatment. I may also be required to sign further consent for certain medical procedures.

I consent for Women's Clinic of Lincoln, P.C. to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

The undersigned further acknowledges that they are financially responsible for all charges whether or not they are covered by insurance.

Signature_____Date:_____

Printed Name_____

Relationship to patient of above signed, if other than patient:_____

For Office Use Only

Medical Record #_____

Received by_____Date:_____