wooster ob•gyn

Emily Benekos, M.D., FACOG
S. Holmes Mason, M.D., FACOG
David Seals, M.D., FACOG
Anne Shriner, M.D., FACOG
John Weeman, M.D., FACOG

WOOSTER OB/GYN CONSENT FORM

By signing this document, I authorize:

1. Wooster OB/GYN to file all my insurance claims with my insurance company.
2. Wooster OB/GYN to exchange information with my insurance company to verify benefits, confirm payor information (primary vs. secondary), check claim status, or pre-certify a hospital admission.
3. Wooster OB/GYN to make appeal(s) with my insurance company for claims payment.
4. Wooster OB/GYN to initiate a complaint against my insurance company for any reason on my behalf.
5. My insurance company to make all checks payable to Wooster OB/GYN.
6. My insurance company to make checks payable to me (if my current policy prohibits payment to the physician directly) and mail them to: *546 Winter St., Suite 100, Wooster, OH 44691-2339*.
7. My physician to deposit all checks payable to me into the business account for payment of my insurance claims.
8. My financial responsibility for all deductible amounts, coinsurance, and services not covered by my insurance.

In case we are unable to reach you by phone, please provide a name and phone number for an additional contact person below.

Name of Contact: _____

Contact Phone #: _____

PLEASE INDICATE BELOW ANY PERSONS (BY NAME) WITH WHOM WE HAVE YOUR PERMISSION TO DISCUSS YOUR CARE (i.e. spouse, mother, father, etc.) IF NO ONE, WRITE NONE. I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

It will be your responsibility to update and inform this office of any changes to be made on this form.

Name	***Relationship***
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient Signature ***Date***