

Patient Label

**LIBERTY HOSPITAL  
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY  
PRACTICES AND PATIENT RIGHTS**

By signing this document, I acknowledge that I have received a copy of Liberty Hospital's Notice of Privacy Practices and Patient Rights.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_

Patient Representative/Relationship Signature:

\_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_

Witness: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_

**Liberty Hospital Use Only:**

If the patient's signature was not obtained, please describe reason why below:

Patient refused to sign Acknowledgement.

Patient unable to sign Acknowledgement due to emergent condition.

Other: Describe below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Liberty Hospital is required by law to make a good faith effort to obtain a written acknowledgement from the patient receiving treatment regarding receipt of our Notice of Privacy Practices. A patient's failure or refusal of this acknowledgement should not interfere with delivery of treatment. 45 CFR 164.520

Liberty Hospital is required to inform each patient of their patient rights in advance of providing or stopping care. 42 CFR 482.13.a (1) Interpretive Guidelines

\*DT027

60-150 DT0274 04/17R



*Charles W. Beggs, M.D., FACS*  
*Anna Clark Gibson, M.D., FACS*  
*Kirstie Van Ry, M.D.*

Board-Certified, Members of the American College of Surgeons  
2521 Glenn Hendren Drive, Suite 108 Liberty, Missouri 64068 P 816-781-3515 F 816-781-3517 [www.libertyhospital.org](http://www.libertyhospital.org)

## Financial Policy

1. Fees are due and payable at the time of your appointment. If we are contracted with your insurance, you will be billed any remainder after we hear from them. As a courtesy, we accept cash, checks, Visa, Discover, and Master Card.
2. If you have an HMO or PPO insurance with a designated primary care physician, please make sure you have selected a physician in our office. If you present us with the incorrect insurance card or information, you will be required to pay the entire fee including any lab services.
3. All co-pays must be paid at the time of your service
4. Not all services are a covered benefit in all contracts. If you have a question regarding benefits, you need to call your insurance company prior to your office visit and check your benefits. Your insurance policy is a contract between you and your insurance company.
5. All services must be paid in full within 30 days after your insurance has paid their portion. If your visit is due to a Motor Vehicle Accident, payment in full is due at the time of the service.
6. The person who brings a child for care is ultimately responsible for their bill. The physician will not get involved in court decisions or support disputes.
7. Accounts become past due after 30 days. We reserve the right to send an account to collections if not paid in full
8. All returned checks must be paid with cash or money order within 5 working days or they will be turned over to the prosecuting attorney's office.
9. If you have any questions, please call our billing office at 816-407-4200.
10. All deductibles and co-payments for Obstetric (OB) services must be paid in full by the 7th month with regular payments due each month by cash, check or credit card.

I hereby acknowledge that I have read, understand, and agree to the terms of this document relating to insurance coverage and payment of my bill.

\_\_\_\_\_  
PATIENT/GUARDIAN'S SIGNATURE

\_\_\_\_\_  
PRINT PATIENT'S NAME & BIRTH DATE

\_\_\_\_\_  
DATE

### Signature On File

I authorize use of this form on all my insurance submissions. I authorize release of information to all of my insurance companies. I authorize direct payment to The Surgeons Clinic. I permit a copy of this authorization to be used in place of the original. I understand I am financially responsible for all charges whether or not covered by insurance.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE



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## Permission to Disclose Information to Those Involved in My Care

I hereby allow The Surgeons Clinic to disclose the following Protected Health Information to the following people that are involved with my healthcare or payment (please mark each that you allow):

- Appointment times and dates
- Tests that have been performed
- Test results
- Billing/payment information
- Other health information

To the following people who are involved with my healthcare or payment information: (please mark all who apply and list his/her names and telephone numbers)

- Spouse \_\_\_\_\_ Phone: \_\_\_\_\_
- Friend \_\_\_\_\_ Phone: \_\_\_\_\_
- Child(ren) \_\_\_\_\_ Phone: \_\_\_\_\_
- Other \_\_\_\_\_ Phone: \_\_\_\_\_

May a confidential message (i.e. appointment information, prescription information, test results) be left on your answering machine or voicemail (please circle how you wish to receive messages)?

- Yes, at home, cell phone or work
- Yes, only at home
- Yes, only on cell phone
- No, DO NOT leave any messages

Patient Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If patient is a minor, please complete the following information:

Mother's name/contact number: \_\_\_\_\_

Father's name/contact number: \_\_\_\_\_