



## Patient Consent

**Yes**  **No** **CONSENT FOR TREATMENT:** By signing this form, I consent to and authorize my health care provider to examine and treat me. I understand that this could include lab tests, education, or other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment.

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**Yes**  **No** **BILLING AUTHORIZATION:** I hereby authorize Associates in Women's Health, P.A. to release requested medical information to my insurance company to collect payment for any changes incurred.

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**Yes**  **No** **ASSIGNMENT OF BENEFITS:** I hereby request that payment of insurance benefits be made directly to Associates in Women's Health, P.A. on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered to my dependent or myself. If, for any reason, my insurance carrier does not pay and portion of my bill, I agree to pay any portion promptly.

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**Yes**  **No** **PATIENTS' RIGHT TO PRIVACY:** I acknowledge that I have received a copy and/or have been made aware of Associates in Women's Health, P.A. privacy practices, which are posted in the reception area. If I would like a copy of the HIPAA notice, I will ask for one.

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**Yes**  **No** **DISCLOSURE OF PRESENCE:** I understand that during my visit, my friends, family, employers or others may call to inquire about my presence at Associates in Women's Health, P.A. I authorize you to disclose information about my presence at this facility to the following people: \_\_\_\_\_.

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**Yes**  **No** I hereby authorize Associates in Women's Health, P.A. to verbally communicate regarding my care with:  
Family member/Caregiver \_\_\_\_\_  
Name Relationship

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**Yes**  **No** I authorize the staff at Associates in Women's Health, P.A. to leave messages on my phone numbers that are listed in my file.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_