

Date: _____

West Suburban Women’s Health, Ltd.

CONSENT FORM

Patient Name Printed: _____ Date of Birth: _____

Directions: Initial and complete each section below and sign in the box at the bottom of the page.

* **Consent to Treat:**

I hereby authorize and consent to the performance of examinations, diagnostic procedures, injections, and treatments which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

* **Consent to Release Information and Assignment of Benefits:**

I understand that I am responsible for any fees for services rendered for myself and/or for my children (if applicable). I hereby authorize the physicians of WSWH to furnish information to my insurance carrier concerning all conditions including those that may reference drug abuse, alcohol abuse, mental illness or HIV status. I hereby assign to WSWH payments made by my insurance carrier until such time as I revoke this in writing.

* **Patient Financial Responsibility**

A complete copy of WSWH’s Financial Policy is available upon request at the reception desk. I understand that WSWH will submit the charges for my visit to my primary and secondary insurance carriers. If there are any questions regarding coverage, benefits, or payment for services provided, I understand that it is my responsibility to resolve them. I also understand that I will be notified of the balance due on my account via a statement and that any balance over 30 days old is my responsibility, with payment due from me. In the event my account is placed with an agency for collection purposes, I understand that I am responsible for all collection agency fees (up to 35% of the balance placed for collection). In addition, I will be responsible for all court costs, filing fees, and attorney fees should this account require litigation. The undersigned agrees to pay all collection costs incurred in the amount of 35% of the unpaid balance should the unpaid balance be referred to a collection agency. If my account is referred to a collection agency more than once, I understand the decision may be made to dismiss me from the practice. The full financial policy can be provided at the front desk or on our website at wswomenshealth.com. **I also understand that if I fail to cancel an appointment less than 24 hours in advance or no-show for an appointment, I will incur a fee of \$40.**

* **Medicare Assignment of Benefits**

I request that payment of authorized Medicare benefits be made on my behalf to West Suburban Women’s Health for services provided to me by the above physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. This assignment of benefits is to remain in effect until I choose to revoke it in writing.

* **Medi-Gap Assignment of Benefits (Medigap = Medicare Secondary Insurance)**

I request that payment of authorized Medi-Gap benefits be made on my behalf to West Suburban Women’s Health for services provided to me by the above physicians. I authorize any holder of medical information about me to release to my Medi-Gap insurer any information needed to determine these benefits or the benefits payable for related services. This assignment of benefits is to remain in effect until I choose to revoke it in writing.

Signature

My signature in the box below indicates my knowledge of and agreement with all of the above. Further, I understand and agree that my consents/assignments remain in effect until I choose to revoke them in writing.

_____	_____
(Signature of patient or authorized representative)	(Printed name)
_____	_____
(Name of patient if different from above)	(Date of Birth)

(If signed above by representative, relationship of signer to patient)	