West Suburban Women's Health, Ltd.

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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.

*_____ **HIV Testing:**
I understand that if I am pregnant, I will be screened for HIV as part of my prenatal labs and in my 3rd trimester. I understand I have the right to opt out of HIV screening by notifying my physician and completing the "HIV Testing: To Opt Out of Testing" form.

*_____ **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.

*_____ **Electronic Prescribing Authorization**
We have recently implemented a new Electronic Prescribing system that allows us to automatically import your medication history from outside practices and pharmacies. In order to transfer your current and past medication list to our electronic medical record, we must have your consent.

*_____ **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) (Today's Date)

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

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