WEST SUBURBAN
WOMEN'S HEALTH

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PATIENT 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 Telemedicine**
I hereby consent to receiving treatment via a HIPAA compliant telemedicine platform. I understand that telemedicine involves receiving healthcare services through secure electronic communication technologies such as video, telephone, or patient portals. I understand that telemedicine has limitations and may not be appropriate for all conditions, and that an in-person visit or follow-up care may be recommended. I agree to provide complete and accurate information about my medical history, medications, allergies, and current health concerns. I understand that technical issues, incomplete information, or limitations of virtual care may affect diagnosis or treatment. I acknowledge that, despite reasonable security measures, there is a small risk of unauthorized access to my health information, which may be shared as permitted for treatment, payment, and healthcare operations. I understand that recording the visit is prohibited, that I may request access to my medical records, and that I am responsible for any applicable copayments, coinsurance, or other out-of-pocket costs. I understand that I may refuse or withdraw consent for telemedicine services at any time without affecting my right to receive future care.

*_____ **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.

*_____ **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.

*_____ **Annual Preventative/Wellness Visit:**
I understand that if my provider addresses a significant problem or abnormality during my annual preventative/wellness visit, an office visit may be billed in addition to my preventative visit. This charge may incur a copay or additional expense to me, which is solely determined by my insurance benefits.

*_____ **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 providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents information needed to determine 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

Patient Signature:_________________________________ Date_________________________