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.

*_____ **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.-s how 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 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)