WOMANKIND
OBSTETRICS and GYNECOLOGY

WOMANKIND OB/GYN GENERAL CONSENT

Consent to Medical Care and Treatment: I consent to all medical and surgical care, examinations, and tests which are determined to be necessary for me while I am a patient at Womankind OB/GYN. I understand that the practice of medicine and surgery is not an exact science and that medical treatment may involve risks, injury, or even death. I acknowledge that no guarantees have been made to me as to the result(s) of any treatment, procedure, or examinations to be performed on me while I am a patient of Womankind OB/GYN

Refusal of Treatment: I understand that if I refuse treatment that is suggested for me or I do not complete a treatment protocol recommended to me, I will not hold WOMANKIND OB/GYN nor any individual responsible for the consequences of my refusal or incompletion.

Release of Information: I authorize WOMANKIND OB/GYN to disclose copies of all or any part of my medical records obtained in the-course of my diagnosis and treatment to any insurance carrier, workers compensation carrier, welfare agency, or any other entity, which may be providing financial assistance for my hospital, medical and/or nursing care. I understand that this disclosure may include information concerning Human Immunodeficiency Virus (HIV) testing, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related condition(s), psychiatric condition(s), and/or alcoholism or drug abuse. I also authorize the release of medical information for utilization and quality assurance review to my insurers or their subcontractors and as required by any city, state, or federal laws. I authorize WOMANKIND OB/GYN to disclose medical information to my family physician, referring physician, or any other provider directly involved in my medical care. I hereby give my expressed consent to WOMANKIND OB/GYN and its agents to contact me at any phone number (including my cellular phone number) that I have given to WOMANKIND OB/GYN personnel for a legal purpose related to my care at WOMANKIND OB/GYN and any other recommended follow up or future care, by means including the use of either automatic telephone dialing systems or other computer-assisted technology. This consent is subject to written revocation by the patient or without revocation will expire one year from this date.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me or the patient named below, I hereby assign to WOMANKIND OB/GYN all right, title, and interest in and to any third-party benefits due from any and all insurance policies employee benefit plans and/or responsible third-party payers in an amount not to exceed WOMANKIND OB/GYN'S regular and customary charges for the health care services rendered. I authorize such payments from my insurance carriers, third-party payers, and any other third-parties. I consent to any request for review or appeal by WOMANKIND OB/GYN to challenge a determination of benefits made by a third-party payer, insurance carrier or employee benefit plan. Except as required by law, I assume responsibility for determining in advance whether the services provided to me are covered by my insurance or other third-party payer.

Financial Responsibility: Subject to applicable law and the terms and conditions of any applicable contract between WOMANKIND OB/GYN and a third-party payer, and in consideration of all health care services rendered or about to be rendered to the patient named below, I agree to be financially responsible and obligated to pay WOMANKIND OB/GYN for its total charges not paid under the "Assignment of Benefits" made below. All other balances must be paid within thirty (30) days after receipt of a statement. I understand that I will be responsible for the costs of any services rendered to me that are not eligible for benefits under Medicare, Medicaid, insurance or other payers.

Statement to Permit Payment of Medical Benefits to Provider and Physician(s): I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf directly to WOMANKIND OB/GYN and to physicians and groups providing medical care to me.

Privacy Notice: I have been offered a copy of WOMANKIND OB/GYN Notice of Privacy Practices within the past year.

Nondiscrimination Statement: WOMANKIND OB/GYN complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ethnicity, religion, culture, language, age, disability, socioeconomic status, sex, sexual orientation, and gender identity or expression in its health programs and activities.

<u>Acknowledgment</u>

By signing below I acknowledge that I have read and understand this Consent and Authorization and that I have been given the opportunity to ask questions and receive clarification so that I fully understand and agree to this Consent and Authorization:

Patient Name (printed): _____ Date of Birth: _____

Patient Signature: _____

Signature of Patient's Authorized Representative: _____