Advanced Women's Care Center, SC

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PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided ADANCED WOMENS CARE CENTER and its employees or designees. I authorize the mental and physical healthcare serviced deemed necessary or advisable by my caregivers to address my needs, (___)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION. I authorization use and disclosure of my personal health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my care, or for the purpose of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or its designated agent. (___)

ASSIGNMENT IF INSURANCE BEBEFITS/PAYMENT GUARANTEE/COLLECTION FEE. I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am Financially responsible to the Practice for any covered or non-covered services, as defined by insurer. I understand that if my account balance becomes overdue and the account is referred to a collection agency, I will be responsible for the costs of collecting including reasonable attorneys fees. (___)

PRIVACY POLICY. I acknowledge having received the Practice's, "Notice of Privacy Policies." My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the practice has already made disclosures with my prior consent. (___)

ROUTINE COMMUNICATION OF MEDICAL INFORMATION. I acknowledge the the present communication method(s) that my physician and his/her staff to confirm appointments, inform me of test results and changes to my treatment plan are acceptable to me. I acknowledge that I can request a reasonable alternative method of communication by listing it below. (___)

________________________________ ___________ _______
Patient or Authorized Person Signature **Relationship** **Date**

____

Witness Signature **Date**

Patient unable to sign. Verbal Consent given. Reason:_______________________