Women's Health & Surgical Services

PATIENT INFORMATION (Please print)

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address: _____ City,State,Zip: _____

Home: _____ Cell: _____ Work: _____

Email Address: _____ DOB: _____

Social Security Number: ___-___-___

Primary Care Provider: _____ Pharmacy: _____

RESPONSIBLE PARTY INFORMATION (if not self) (information used for patient balance)

Responsible Party: ☐ Self ☐ Guarantor Date of Birth: _____

Responsible Party Name: (Last) _____ (First) _____

Address: _____ Phone Number: _____

City/State/Zip: _____

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _____ (First) _____

Phone Number: _____ Relationship: _____

Address: _____ City/State/Zip: _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT : You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, and diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent for is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examination, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature or patient or personal representative: _____ Date: _____

Printed Name: _____ Relationship: _____