PATIENT CONSENT FORM

Patient Name: _____ Date of birth: _____/_____/_____

CONSENT FOR MEDICAL EVALUATION AND TREATMENT

- I consent to medical evaluation and treatment with office-based procedures necessary for my health care. I understand that this consent shall not expire. I accept that there are no guarantees of protection of my records from court ordered release.
- I understand that I can request restrictions on how my health information is used or disclosed to carry out treatment or health operations, but that the Women's Health Center of Clarksville is not required to agree to my requested restrictions.
- I consent to the disclosure of my protected health information for the purpose of medical diagnosis, providing treatment, obtaining payment, or to conduct necessary health care operations, and to authorize direct payment of medical insurance benefits to the Women's Health Center of Clarksville for services performed. I also understand and agree that I am responsible for payment of all valid charges not paid by my medical insurance.
- **Laboratory services may be provided by PATHGROUP** - an outside contracted reference lab. Any lab charges accrued for self-pay will be billed to the patient through PATHGROUP. I accept responsibility for valid lab charges not covered by my medical insurance plan.
- **Certain ultrasound services may be provided by The Perinatal Group** - an outside contracted group. Any ultrasound charges accrued for self-pay will be billed to the patient through The Perinatal Group. I accept responsibility for valid ultrasound charges not covered by my medical insurance plan.
- I have received and understand the Women's Health Center of Clarksville's Notice of Privacy Practices.
- I have the right to refuse signature of this consent, but in doing so I am required to pay for all services up front at the time of service.

NO SHOW POLICY

It is our policy that you notify the office at least 24 hours in advance if you are unable to keep an appointment. In the event that you no show an appointment more than once, there will be a $25.00 no show fee charged to you (not covered by insurance). Three or more missed appointments may result in dismissal from the practice.

NO CHILD POLICY

There is a strict no child policy at the Women's Health Center of Clarksville. **The only exception is newborn babies under the age of 6 weeks old. We have this strict policy in place for the safety, health and well-being of the pregnant women and their unborn children. Small children can carry infectious illnesses that can compromise the sensitive immunity of pregnant women and their unborn babies. Please do not bring children inside the building or your appointment will be rescheduled. Thank you for your understanding.

HIPAA (Health Insurance Portability and Accountability Act) Personal Representative Form

By listing my personal representatives and signing below, I authorize the following individual(s) to be able to obtain or request my protected health information. This information may include clinical care information as well as billing and health insurance information. I understand that the protected health information released to the following recipient(s) may be further disclosed by that recipient(s).

The person(s) listed below are my personal representatives and will have access to my protected health information:

Name (please print)	Date of birth	Phone Number	Relation
_____	_____/_____/_____	_____-_____-_____	_____
_____	_____/_____/_____	_____-_____-_____	_____

_____ Please check here if you would like to list one of the above people as your **emergency contact**
Please print name and phone # of emergency contact: _____ _____-_____-_____

Patient Signature: _____ Date: _____
Parent/Guardian Signature if patient is a minor: _____