



Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
• Administration of any needed anesthetics
• Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
• Use of prescribed medication
• Performance of diagnostic procedures/tests
• Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that NEW HORIZONS: WOMEN'S MEDICAL GROUP includes consent at satellite offices under common ownership.

I, the undersigned, acknowledge that NEW HORIZONS: WOMEN'S MEDICAL GROUP will use and disclose my information for the purposes of treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to NEW HORIZONS: WOMEN'S MEDICAL GROUP or benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized person to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and the Public Health Department and appropriate counseling will be offered.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to NEW HORIZONS: WOMEN'S MEDICAL GROUP

I acknowledge that I have been given the NEW HORIZONS: WOMEN'S MEDICAL GROUP Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: \_\_\_\_\_

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

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name: \_\_\_\_\_
Name: \_\_\_\_\_

Patient (or Responsible Party) Signature

Original - Practice

Date

HIM.PRI.001, HIM.PRI.007

\* Print:

Revision Date: June 21, 2010

Patient Registration Form

PATIENT INFORMATION

(Please Print)

Dr. Mr. Mrs. Ms. Jr. Sr. Other
Patient's Name (Last) (First) (Middle)
Also Known As Name (Last) (First)
Marital Status Married Single Divorced Widowed Legally Separated Other
Social Security Number Female Male Date of Birth
E-Mail Address
Phone Numbers Work Day Evening Home Day Evening Cellular Pager
Address
City, State, ZIP (+4)
Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed
Employer Occupation
Emergency Contact Name Phone Number
Emergency Contact Relationship to Patient
Referring Provider Name

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last) (First) (Middle)
Also Known As Name (Last) (First)
Social Security Number Female Male Date of Birth
E-Mail Address
Phone Numbers Work Day Evening Home Day Evening
Address
City, State, ZIP (+4)
Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed
Employer Employer Phone Number
Patient Relationship to Responsible Party

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured Patient Relationship to Insured
Insured Employer Name
Insurance Company/Phone Number
Subscriber ID (Policy Number) Group ID Copay Amount
Effective Date Termination Date Female Male
Insured Date of Birth Insured's Social Security Number
Insurance Company Address

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured Patient Relationship to Insured
Insured Employer Name
Insurance Company/Phone Number
Subscriber ID (Policy Number) Group ID Copay Amount
Effective Date Termination Date Female Male
Insured Date of Birth Insured's Social Security Number
Insurance Company Address

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature Date