Dedicated to Women ObGyn

Use & Disclosure/Consent for Treatment Form

MRN#: _____ Date: _____

_____ _____
(Last Name) (First Name) (M.I.) Date of Birth

I consent to treatment by Dedicated to Women ObGyn and grant permission to the physicians, employees and other persons authorized to render routine medical care that includes, but is not limited to diagnostic procedures and medical treatment, and to carry out all orders deemed advisable by my provider. I understand that no guarantee or assurance has been made as to the results that may be obtained.

My primary contact number is: _____ ☐ Home ☐ Mobile ☐ Work

Confidential messages may be left on: ☐ Home Phone ☐ Mobile Phone ☐ Work Phone

List any additional numbers:_____

- **Please provide an EMERGENCY CONTACT:**

_____ _____ _____
(Name) (Relationship to Patient) (Contact Number)

- **List name and contact number of any person, whom we may inform about your general medical condition, diagnosis, appointment information, and billing statement:**

_____ _____ _____
(Name) (Relationship to Patient) (Contact Number)

_____ _____ _____
(Name) (Relationship to Patient) (Contact Number)

_____ _____ _____
(Name) (Relationship to Patient) (Contact Number)

I have read or been offered a copy of the Dedicated to Women OB-GYN Privacy Notice. Additional copies may be found in our offices, online @ www.dedicatedtowomenobgyn.com, or you may call our office and ask a staff member for a copy.

I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE. In the event that any account is placed with a third party for collection, I agree to pay the collection agency fee of 35% in addition to the balance owed on the account. I authorize release of any medical information necessary to process my claims and request payment of insurance benefits be paid directly to Dedicated to Women, ObGyn, PA. I also authorize releases of medical information necessary to process disability, loss of income, or any other forms requested by me or my insurance company on my behalf. I further authorize the release of above requested information via FAX and/or electronic transmission.

_____ _____
(Signature) (Date)