Date:____________________

West Suburban Women's Health, Ltd.

CONSENT FORM

Patient Name Printed:____ Date of Birth:______________

Directions: Initial and complete each section below and sign in the box at the bottom of the page.

***______ Consent to Treat:**

I hereby authorize and consent to the performance of examinations, diagnostic procedures, injections, and treatments which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

***______ Consent to Release Information and Assignment of Benefits:**

I understand that I am responsible for any fees for services rendered for myself and/or for my children (if applicable). I hereby authorize the physicians of WSWH to furnish information to my insurance carrier concerning all conditions including those that may reference drug abuse, alcohol abuse, mental illness or HIV status. I hereby assign to WSWH payments made by my insurance carrier until such time as I revoke this in writing.

***______ Patient Financial Responsibility**

A complete copy of WSWH's Financial Policy is available upon request at the reception desk. I understand that WSWH will, as a courtesy to me, submit the charges for my visit to my primary and secondary insurance carriers. If there are any questions regarding coverage, benefits, or payment for services provided, I understand that it is my responsibility to resolve them. I also understand that I will be notified of the balance due on my account via a statement and that any balance over 30 days old is my responsibility, with payment due from me. In the event my account is placed with an agency for collection purposes, I understand that I am responsible for all collection agency fees (up to 30% of the balance placed for collection). In addition, I will be responsible for all court costs, filing fees, and attorney fees should this account require litigation.

***______ Consent for Credit Card Payment**

I hereby give permission to charge any balance due on my account to my credit card. I understand that a courtesy call will be made to me to obtain my authorization before any charge is made on my credit card.

Card Type:__________________________ Card Number____

Exp Date:___________________________ Security Number on back of card_____________________________

***______ Medicare Assignment of Benefits**

I request that payment of authorized Medicare benefits be made on my behalf to West Suburban Women's Health for services provided to me by the above physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. This assignment of benefits is to remain in effect until I choose to revoke it in writing.

***______ Medi-Gap Assignment of Benefits (Medigap = Medicare Secondary Insurance)**

I request that payment of authorized Medi-Gap benefits be made on my behalf to West Suburban Women's Health for services provided to me by the above physicians. I authorize any holder of medical information about me to release to my Medi-Gap insurer any information needed to determine these benefits or the benefits payable for related services. This assignment of benefits is to remain in effect until I choose to revoke it in writing.

Signature

My signature in the box below indicates my knowledge of and agreement with all of the above. Further, I understand and agree that my consents/assignments remain in effect until I choose to revoke them in writing.

____

(Signature of patient or authorized representative) (Printed name)

____

(Name of patient if different from above) (Date of Birth)

____

(If signed above by representative, relationship of signer to patient)