WOMEN'S MEDICAL CENTER, P. C.

CONDITION OF ADMISSION/TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

Note: As used on this form, "WMC" means Women's Medical Center, P.C., its physicians, and its employees.

1. **CONSENT FOR CARE AND TREATMENT:** I hereby authorize WMC to provide services as ordered by my physician. I acknowledge that no guarantees have been given to me as a result of my treatment or examination.

2. **MEDICAL, SURGICAL AND PSYCHIATRIC CONSENT:** The undersigned consents to any x-ray examination, laboratory procedures, urine drug screening, anesthesia, medical or surgical treatment, blood or blood products or services rendered the patient under the general and special instructions of the physician.

3. **RELEASE OF INFORMATION:** WMC may disclose all or any part of the patient's medical record required by insurance companies, workers compensation carriers, welfare funds, hospital services and other medical services companies for the purpose of reimbursement. WMC may disclose any information concerning a patient's case, when it is necessary or appropriate for medical research. Should the patient's care include furnishing treatment or referral for alcohol and drug abuse, psychiatric conditions, sexually transmitted diseases such as HIV and AIDS, the undersigned authorizes release of information as specified above for reimbursement purposes only. The undersigned authorizes WMC to release medical information upon request, to any healthcare facility or physician for the purpose of facilitating my continuing care and treatment. I understand that this authorization may only be revoked in writing. This revocation shall not have the effect of revoking any disclosures, which may have been made prior to the receipt by WMC of such revocation.

4. **AUTHORIZATION FOR REVIEW OF MEDICAL RECORDS:** The office is hereby authorized to review the patient's chart, in a confidential manner, at any committee meeting for evaluation and improvement of patient care.

5. **PERSONAL VALUABLES:** The office shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, documents, other articles of unusual value, or any other personal property.

6. **FINANCIAL AGREEMENT:** In consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the office in accordance with the regular rates and terms of WMC. It is understood that the undersigned as patient/guarantor is financially responsible for any charges not covered by insurance. Should the account be referred to any attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

7. **MEDICARE CERTIFICATION:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductible and co-insurance.

8. **CHAMPUS AUTHORIZATION:** I request that payment of authorized benefits be made either to me or on my behalf to my physician for any services furnished to me by my physician. I authorize any holder of medical information about me to release to CHAMPUS and its agents any information needed to determine these benefits or the benefits payable for related services. This paragraph applies only to those patients with CHAMPUS benefits.

9. **TESTING FOR PRESENCE OF HUMAN IMMUNODEFICIENCY VIRUS (HIV/AIDS) AND HEPATITIS B AND C VIRUS.** Although informed consent will be obtained from patients when these tests are ordered by the physician, these tests may be performed without written consent of the patient if any employee or agent of WMC is exposed to blood or any body fluids through the skin, mucous membranes, or open wounds. The results of the tests will only be released to the exposed person, and no one else unless required or authorized by the legal system.

Exceptions/Corrections to the above by the patient or legal agent: ____________________________________

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The undersigned certifies that he/she has read the foregoing, and is the patient, or is duly authorized by the patient as the patient's general agent, to execute the above and accept its terms.

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Signature of Patient

Date of Birth ______________________

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If Minor: Signature of Patient's Legal Guardian

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If Minor: Relationship to patient

Date ______________________

Witness ____