Consent for Treatment

I authorize and consent to the rendering of medical care, including diagnostic procedures and medical treatment by authorized members of Plaza Gynecologic Oncology as many in their professional judgment be necessary for the below named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment.

Assignment of Insurance Benefits

Patient-Physician Agreement: I, the undersigned, authorize Plaza Gynecologic Oncology to release any information acquired in the course of my examination or treatment to my insurance company(s) or another physician. I, recognizing that the medical insurance I possess may not completely cover the fee(s) for professional services rendered me; hereby agree that I am responsible for said fee(s). I authorize payment directly to me for their services. A photocopy hereof shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

Authorization to Release Information

I authorize Plaza Gynecologic Oncology to release any information requested by the insurance company necessary to collect benefits under any policy we make claim against for services on this or a related date of service.

Guarantee of Payment

I understand that office visits are to be paid for at the time of service unless other arrangements have been made. I understand that I am responsible for the balance not covered by insurance. I understand that Plaza Gynecologic Oncology does not accept any insurance policy assignment as a guarantee of full payment.

Patient Signature:

X

(Patient or Parent/Guardian if under 18 years of age)

Relationship of Guardian

Date
PRIMARY INSURANCE

Patient's Relationship to policy holder: □ Myself □ Spouse □ Child □ OTHER: ________________

Name of Insurance Company: ____________________________________________________________

Insurance Company Address: ____________________________________________________________

City: ___________________________  State: ___________________________  Zip: ________________

ID# ____________________________  Group #: ________________________________

Insurance Company's Phone Number: ______________________________________________________

Policy Holder: ___________________________  Policy Holder's Date of Birth: ____-____-____

Policy Holder's Social Security #: __________-_______-__________

Policy Holder's Address: ________________________________________________________________

City: ___________________________  State: ___________________________  Zip: ________________

SECONDARY INSURANCE

Patient's Relationship to policy holder: □ Myself □ Spouse □ Child □ OTHER: ________________

Name of Insurance Company: ____________________________________________________________

Insurance Company Address: ____________________________________________________________

City: ___________________________  State: ___________________________  Zip: ________________

ID# ____________________________  Group #: ________________________________

Insurance Company's Phone Number: ______________________________________________________

Policy Holder: ___________________________  Policy Holder's Date of Birth: ____-____-____

Policy Holder's Social Security #: __________-_______-__________

Policy Holder's Address: ________________________________________________________________

City: ___________________________  State: ___________________________  Zip: ________________
GENERAL INFORMATION

Who is responsible for payment? □ Myself □ Other

Responsible Party Name: ___________________________ Their Date of Birth: _______ - _______ - _______

Relationship to Patient: □ Self □ Spouse □ Child □ Other Social Security #: _______ - _______ - _______

Address: _____________________________________ Phone #: ___________________________

Have you ever been seen as patient at one of our Washington Regional Medical System Clinics? □ Yes □ No?

If Yes, When?: _______ / _______ / _______ Where?: ________________________________

RELEASE OF INFORMATION (spouse, children, parents, etc)

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: ___________________________________ Relation to Patient: ______________________

Name: ___________________________________ Relation to Patient: ______________________

Name: ___________________________________ Relation to Patient: ______________________

Preferred Language: □ English □ Spanish □ Marshallese □ Arabic □ DECLINE □ OTHER: ______________________

Race: □ White □ African American □ Asian □ Native Hawaiian/Other Pacific Islander

□ Native American Indian/Alaskan □ Hispanic □ Unknown □ DECLINE

Ethnicity (Origin): □ Not Hispanic or Latino □ Hispanic or Latino □ Unknown □ DECLINE

Preferred Communication Method: □ Print □ Save to Flash Drive □ DECLINE

Wellness Reminders: □ Mail □ Cell Phone □ Home phone □ Work Phone □ DECLINE

PREFERRED PHARMACY: ____________________________ LOCATION: __________________________

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I authorize WRMC operators in their role as an answering service to release my protected health information utilizing the pager system or text messaging. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X ____________________________ Date: _______ / _______ / _______

Signature (Patient or Parent/Guardian if minor)