CONSENT TO TREATMENT AND TESTING
INSURANCE AUTHORIZATION

Consent to Treatment and Testing: I hereby consent to the physicians of Lifespring Women's Healthcare to perform or order the performance of any medical treatment, including testing for infectious disease, for the patient with a distinct understanding that the doctor and the doctor's assistants do all they deem necessary. I understand that during my treatment, the physician may either specifically or by previous arrangements request that other providers render professional services on the patients' behalf.

NOTICE OF PRIVACY PRACTICES: Received: Yes _____ No _____
No, State reason: _____Patient refused to check: _____

PLEASE CHECK ONE OF THE FOLLOWING:

SHARING PROTECTED HEALTH INFORMATION: I have indicated below, by my checkmark (check only one) my desire regarding sharing Protected Health Information (PHI) with family, friends, interpreters or others involved in my care or payment for my care.

□ I understand that by taking any of the above noted parties into the treatment room with me, I am allowing the provider to freely discuss my care and treatment in an unrestricted format.

□ I understand that by choosing to restrict PHI information, I must inform my provider in writing what protected health information I do not want discussed in the presence of others

□ I understand that by choosing to object to PHI information being shared, I will not be allowed to have anyone accompany me into the treatment area.

INSURANCE AUTHORIZATION

□ I hereby authorize release of medical information necessary to report a claim to my plan (s). I understand I am financially responsible for all charges whether or not paid by the insurance.

□ Medicare with Supplement: I request that payment of authorized Medicare benefits be made on my behalf to Lifespring Women's Healthcare for any services furnished me by the physician. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named any information regarding my Medicare claims under Title XVII of the Social Security Act. I request that payment of authorized Medigap benefits be made on my behalf to Lifespring Women's Healthcare for any services furnished me by any physician/provider in that practice. I authorize any holder of medical information about me to release to my Medigap or secondary, tertiary insurer any information needed to determine these benefits or the benefits payable for related services.
Medicare Number: _____

_____ _____
Patient Signature Date

_____ _____
Authorized Person Date

To maintain my privacy practices; I authorize the office to release my personal history information in the following manner:

□ A detailed message may be left at home. HOME NUMBER: _____

□ A message with a call back number only

□ A detailed message may be left at my work. WORK NUMBER _____

□ A message with a call back number only

Written Communication

□ It is okay to mail to my home

□ It is okay to mail to my work

□ It is okay to fax information to me at the following number: _____

□ I only allow _____ (**specific person**) to receive the following information:

- □ Appointment schedule information
- □ Billing information
- □ Lab test or reports
- □ Prescription or medication information

NAME:_____ DATE: _____

SSN: _____