CONSENT TO TREATMENT AND TESTING
INSURANCE AUTHORIZATION

Consent to Treatment and Testing: I herby 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 or doctor's assistant do all they deem necessary. I understand that during my treatment, the physician may either specifically, or by previous arrangement request that other providers render professional services on the patient's behalf .

NOTICE OF PRIVACY PRACTICES: Receive: 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 check mark (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 additional parties into the treatment room with me, I am allowing the provider to freely discuss my care and treatment in an unrestricted format.

☐ I do not want the provider to freely discuss my care and treatment when anyone other than myself present. I understand that by checking this box, no other parties will be allowed to enter the treatment room with me.

It is ok to let family or friends know that I am here for an appointment or that I have future appointments. (Please check one)

☐ **YES** ☐ **NO**

INSURANCE INFORMATION

☐ **I hereby authorize release of medical information necessary to repost 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 to me by the physician. I authorize any holder of medical information about me to release to Health Care Financing Administrative 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 authorize Medigap benefits be made on my behalf to **Lifespring Women's Healthcare** for any services furnished to me by any physician/provider in the practice. I authorize any holder of medical information about me to release to my Medigap or secondary, tertiary insurance any information needed to determine these benefits payable for related services.
Medicare Number_____

_____ _____
Patient/Authorized Person Signature Date

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

□ A detailed message may be left at my personal number. PHONE NUMBER:_____

□ YES □NO IF SOMEONE ELSE, OTHER THEN MYSELF, ANSWERS A CALL AT THE NUMBER LISTED ABOVE, IT IS OK TO GIVE THEM A DETALED MESSAGE. I UNDERSTAND THAT THIS MESSSAGE COULD CONTAIN PERSONAL MEDICAL INFORMATION

□ 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

I UNDERSTAND THAT LIFESPRING WOMEN'S HEALTHCARE WILL SEND ME INFORMATION IN THE MAIL TO MY HOME THAT COULD CONTAIN APPOINTMENT INFORMATION, LAB/PAP RESULTS, BILLING INFORMATION, OR OTHER PERSONAL HEALTH INFORMATION.

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

□ Appointment schedule information

□ Billing information

□ Prescription or medication information

□ Verbal medical information, which could include: prescription information, lab/pathology results, ultrasound findings, or any other medical record information contained in my personal health record.

□ PLEASE CHECK THIS BOX IF YOU ARE THE ONLY PERSON ALLOWED ACCESS TO YOUR PROTECTED HEALTH INFORMATION.

PATIENT NAME:_____ DATE:_____