Northside
WOMEN'S HEALTH
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Northside Women's Health
Patient Consent and Authorization

1. **Consent to Medical Care and Treatment**
   While at Northside Women's Health, I consent to all medical and surgical care, examinations or tests determined to be necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. If I refuse treatment that is suggested for me, or if I leave against medical advice, I will not hold Northside Women's Health or an individual responsible for any consequences.

2. **Release of Information**
   Our Notice of Privacy Practices provided information about how we may use and disclose protected health information about you. This notice contains a Your Rights section describing your rights under the law. You have the right to review our notice before signing this consent and authorization. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

3. **Acknowledgement of Notice of Privacy Practices**
   I acknowledge that I have received or been offered a copy of Northside Women's Health Notice of Privacy Practices and have had a chance to object to the use of or disclosure of my information.

4. **Financial Responsibility**
   I understand and agree that I am financially responsible for payment of all charges incurred, which are not paid by insurance benefits. I agree to pay Northside Women's Health for charges incurred, including incidentals. I understand that services rendered to me may not be eligible for benefits under Medicare, Medicaid, or other insurances or payors. Services not eligible for benefits may include tests and procedures that are not covered, or those delivered by health care providers who did not participate with my insurance plan. If you are unable to keep an appointment, advanced 24-hour notification is required. Two missed appointments could cause termination of your medical care at our office.

5. **Personal Valuables**
   I understand that Northside Women's Health does not accept responsibility for any lost, stolen or damaged personal items.

6. **ALTERNATIVE MEANS OF COMMUNICATION**
   The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means; such as sending correspondence to the individual's office.

I wish to be contacted in the following manner (circle all that apply):

Home Telephone_____
Ok to Leave message with info? Yes or No
Only leave message with call back number? Yes or No

Cell Phone_____
Ok to Leave message with info? Yes or No
Only leave message with call back number? Yes or No

Work Telephone_____
Ok to Leave message with info? Yes or No
Only leave message with call back number? Yes or No

I would like to have text reminders. Yes or No
I would like to have e-mail reminders. Yes or No
E-mail address _____

Other_____

I have read and understand the above patient consent and authorization form. A copy may be given upon request.

_____ _____

Patient Name (please print) Date Patient Signature (or Guardian) Date