Center For Pelvic Health
100 Covey Drive, Ste 205
Franklin, TN 37067

AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT: I hereby authorize the Practice to provide the medical services, tests, procedures, interventions, drugs and supplies and other care that my doctor, in his professional judgment, decides are needed for my health and wellbeing. My authorization extends to other employees of the Practice. I understand that these services may include tests for communicable diseases, HIV, the presence of therapeutic and non-therapeutic drugs and other tests my doctor believes are necessary for my diagnosis and treatment. I understand that in the event an employee of the Practice is accidentally exposed to my blood/bodily fluids, I hereby consent to the testing of my blood as deemed necessary by the health care provider. I acknowledge that the practice of medicine is not an exact science. No one has guaranteed nor can anyone guarantee the results of the care to be provided.

ASSIGNMENT OF BENEFITS: I assign to the Practice my right to receive payment from third-party payers for care provided by the Practice. Third-party payers include insurance carriers or social security administrators who provide coverage to me. I understand that in billing the insurance company, a diagnosis may be used that is considered confidential information.

CONSENT TO OBTAIN PRESCRIPTION HISTORY: I authorize The Center for Pelvic Health and Its Affiliated Providers to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

RESPONSIBILITY FOR PAYMENT: I will pay for the care and services provided and not paid for by third-party payers, including co-pays and deductibles. I understand that payment for medical services in this office for my dependents or myself is due and payable at the time services are rendered unless other arrangements have been made. It is my responsibility to understand my health insurance benefits and what is and is not covered.

NOTICE OF PRIVACY PRACTICES: The practice's "Notice of Privacy Practices" describes ways in which we may use and disclose medical information. The notice also describes my rights and legal obligations with regard to my medical information. My signature below acknowledges that I have been given or offered a copy of the "Notice of Privacy Practices".

MEDICARE/TENNCARE/TRICARE PATIENTS: If I am a Medicare, TennCare or Tricare patient, I certify that the information I provided when applying for payment under the Social Security Act is correct.

RETURNED CHECKS: I understand that I will be charged a $25.00 fee for any returned checks.

MISSED APPOINTMENT FEE: I understand that I will be charged a $25.00 fee for any missed or cancelled appointment for which I did not provide at least a 24 hour notice of cancellation.

I have read the information on this form or have had it read to me. I have had the opportunity to ask any questions I might have. By voluntarily signing my name below, I indicate that I understand and accept each of these provisions.

_____ _____

Patient or Authorized Representative Signature Date