CENTER FOR PELVIC HEALTH POLICIES AND PROCEDURES

AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT: As the patient, you have the right to be informed about your conditions and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s). I hereby request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions. I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns. In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV, hepatitis B or hepatitis C I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who was exposed. I have read or had read to me and fully understand this consent; I have had the opportunity to ask questions and had these questions addressed. 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.

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.

PATIENT FINANCIAL POLICY: I will pay for the care and services provided and not paid for by third-party payers, including co-pays and deductibles. It is my responsibility to understand my health insurance benefits and what is and is not covered and to address any coverage concerns with my insurance company prior to receiving treatment. It is my responsibility to provide current and accurate insurance information at each visit. I also understand payment is due at the time services are rendered. This includes, but is not limited to co-pays, co-insurance and unmet annual deductibles. The full patient financial policy is available at the front desk and online at our practice website, www.centerforpelvichealth.org.

DELINQUENT ACCOUNTS: We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing. If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT**:** I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

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.

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". A current copy of the Notice of Privacy Practices is also available on the practice's website.

Please initial below:

_____ **I have read the information on this form, Center for Pelvic Health Policies and Procedures, or have had it read to me. I have had the opportunity to ask any questions I might have.**

_____ **I have been provided or offered a copy of the Patient Financial Policy. I also understand that I may at any time access the policy online at the practice's website, www.centerforpelvichealth.org or obtain a printed copy at the office during regular business hours.**

_____ **I have been provided or offered a copy of the Notice of Privacy Practices. I also understand that I may at any time access the policy online at the practice's website, www.centerforpelvichealth.org or obtain a printed copy at the office during regular business hours.**

By voluntarily signing my name below, I indicate that I understand and accept each of these provisions.

_____ _____

Patient or Authorized Representative Signature Date