FEMALE PELVIC MEDICINE & RECONSTRUCTIVE SURGERY
THE FEMALE PELVIC HEALTH CENTER

CONSENT FOR TREATMENT: The undersigned grants authorization to the physicians, associates, and staff at The Female Pelvic Health Center for such treatment and procedures that may be necessary for the patient herein named in accordance with the judgment of the physician. The undersigned acknowledges that no guarantees have been made as to the results of treatments or examinations in the office, or otherwise.

I realize that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law.

AUTHORITY TO REVIEW AND RELEASE RECORDS AND INFORMATION: The undersigned hereby authorizes and requests the physicians, associates, and staff of The Female Pelvic Health Center to furnish and release upon written request to all insurance companies or their representatives insuring the patient named, to The Female Pelvic Health Center and to any specific person herein named below, any and all information with respect to the patient herein named including, but not limited to, the case history, examination, prognosis, treatment medication, x-rays or surgery. Billing agencies which provide specialized services, routinely will receive information necessary for billing purposes. Medical records may also be used for educational or research purposes with the patient protected. Authorization is hereby given to physicians, associates, and staff at The Female Pelvic Health Center to release patient's name, age, sex, and nature of admission and general condition.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: The undersigned understands and hereby releases physicians, associates, and staff at The Female Pelvic Health Center from any responsibility due to loss or damage of any valuables that the patient or the undersigned may keep in his possession in the office or hospital.

PAYMENT GUARANTEE: The undersigned hereby guarantees payment of all fees and charges incurred by patient for services that may not be covered under the insurance plan of the insured. In the event that the undersigned fails to make payment as provided herein or agree to alternative payment arrangements deemed satisfactory by The Female Pelvic Health Center, affirmative collection measures will be initiated. The undersigned agrees to pay all costs of collections, including twenty-five (25%) percent of the unpaid balance as a reasonable attorney's fee in the event that such indebtedness is turned over to any attorney for collection.

ASSIGNMENT OF BENEFITS: I request payment of authorized benefits to The Female Pelvic Health Center for all services rendered. I authorize any holder of medical or other information about me to release to my insurance carrier and its agents, any information needed to determine these benefits or benefits for related services.

The undersigned certifies that (s)he has read the forgoing, that it has been fully explained and that (s)he understands its contents, and hereby agrees to all terms and conditions set forth in the above paragraphs set forth and acknowledges the receipt of a copy if requested.

_____ _____
Patient Signature Date of Signature

_____ _____
Signature of Patient Agent or Representative Relationship to Patient

_____
Witness Signature