Consents of Mid-City OB-GYN, P.C.

CONSENT TO TREAT: I voluntarily consent to medical treatment and diagnostic procedures by Mid-City OB-GYN, P.C. I consent to the testing for infectious diseases, such as but not limited to chlamydia, gonorrhea, syphilis, hepatitis, HIV/AIDS, and testing for drugs if deemed advisable by my physician.

> HIV(Human Immunodeficiency Virus) is the virus that causes AIDS (Acquired Immunodeficiency Syndrome). A positive HIV test means that HIV antibodies have been detected, and that the individual has probably been infected with HIV. A negative test means that the antibody to HIV has not been detected, and the individual has probably not been infected with HIV.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations.

CONSENT TO E-PRESCRIBING PBM: I hereby authorize that Mid-City OB-GYN, P.C. can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

ACKNOWLEDGMENT OR RECEIPT OF NOTICE OR PRIVACY PRACTICES: I acknowledge that I was provided with the Notice of Privacy Practice of the Medical Practice named at the top of this page.

AUTHORIZATION FOR RELEASE OR INFORMATION: I hereby authorize the release of my medical records by Mid-City OB-GYN, P.C. to my attending physician, hospitals and third party payer (whether an insurance co., government agency, employer or self-insurance employer or utilization review organization).

ASSIGNMENT OF BENEFITS: I hereby assign to said physician all right, title and interest to any benefit payable for medical coverage. I direct that such benefits be paid directly to said physician and I will be responsible for any charges accrued and not paid by the insurance company. I understand I am responsible for all co-pays, deductibles, co-insurance and any non-covered services.

CONSENT FOR SHARING of PROTECTED HEALTH DATA and INFORMATION: Please list the names and relationship of family members or other persons, if any, whom we may inform verbally and/or copy of records to about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

1._____ 2._____

TEST RESULTS AND CONFIDENTIAL MESSAGES: Can confidential messages (i.e. appointment reminder, test results, etc.) be on your telephone answering machine or voicemail? I am fully aware that a cell phone is not a secure and private line.

YES_____ NO_____

Patient's Name (PRINT) _____

_____ _____ _____

Signature of Patient or Responsible Party | Responsible Party Relationship to Patient | Date

For Practice Use Only: Witness Signature of Practice Employee

_____Date_____

Doctor_____ Acct. #_____