General Consent to Treat

I have the legal right to consent to medical and surgical treatment because (a) I am the patient or (b) I am the parent/guardian of the patient. All references to "patient", "me" and "my" in this document means:

Patient's Name: _____Date of birth (MM/DD/YYYY):_____

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Highland Gynecology and their designated associates or assistants believe are necessary. This specifically includes a pelvic exam if appropriate. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be made part of the medical record. l understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, nurse practitioners, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.
_____ (Please initial)

Sharing Records for Treatment
We share medical records with other health care providers to allow and promote continuity of care among providers. If you visit another provider, they may have access to your medical record.
_____ (Please initial)

Acknowledgment of Financial Policy
I acknowledge receiving Highland Gynecology's Financial Policy. This Policy explains my financial responsibility and how any past due balances will be handled. A copy may be obtained through the front desk, if you should have questions please contact our office.
_____ (Please initial)

Acknowledgment: Notice of Privacy Practices
I acknowledge receiving Highland Gynecology's Notice of Privacy Practices ("Notice"). The Notice explains how Highland Gynecology may use and disclose the patient's protected health information for treatment, payment and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. If you have questions about the Notice, please contact our office.
_____ (Please initial)

Acknowledgment of Office Information & Policies
I acknowledge receiving Highland Gynecology's Office Information and Policies. By acknowledging this I am accepting the policies as stated. I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.
_____ (Please initial)

Name of Patient's Representative, if patient under 18 (Printed):
_____

Relationship of Patient's Representative if patient under 18:
_____

Signature of Patient or Patient's Representative: _____Date: _____