

PATIENT CONSENT FORM

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.
- Use of prescribed medication
- Performance or diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that COMPLETE WOMEN'S HEALTHCARE to use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to COMPLETE WOMEN'S HEALTHCARE.

I acknowledge that I have been given the COMPLETE WOMEN'S HEALTHCARE Notice of Privacy Practice. I understand that if I have questions or complaints that I should contact the Privacy official.

Patient initial: _____

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its consent.

Patient (or Responsible Party) Signature

Date

Revision Date: March 16, 2007