Ladies First Health Care

Treatment Agreement

1. CONSENT TO TREATMENT

I hereby voluntarily request, consent to and authorize Ladies First Health Care (LFHC) and its physicians, employee(s), their associates, assistants, or other practitioners under their orders to treat me at LFHC office, and to provide medical and surgical treatment, including, but not limited to, diagnostic procedures, x-rays, and administration of medications, as is deemed necessary and advisable. In cases of birth, this consent shall extend to my child/children. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments and examinations in LFHC office.

2. PATIENT'S PERSONAL POSSESSIONS

LFHC is not responsible for any patient's clothing, valuables or other personal belongings left with/by patient. I hereby release LFHC from any liability for any and all personal possessions which I choose to keep with me during my office visit.

3. RELEASE OF INFORMATION

I hereby authorize LFHC, or its designee, to release information, in written form, by phone, or facsimile machine, contained in the patient's medical records. I specifically authorize the release of drug and alcohol abuse records in accordance with Federal regulations and or communications made by me to a social worker or psychologist and/or records pertaining to communicable diseases. I further specifically authorize the release of information regarding: Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), Acquired Immunodeficiency Related Complex (ARC) to:

(a) any third party payor, employer, or insurance company (including but not limited to Medicare, Medicaid, maternal and infant health, Blue Cross/Blue Shield, commercial health insurers, automobile no fault insurers, workers' disability compensation insurers and health maintenance organizations) which are responsible in whole or in part for paying the patient's bill so that LFHC may receive payment or reimbursement for the services provided to the patient.

(b) any health care facility, physician, durable medical equipment supplier or other ancillary services provider to which the patient is referred or transferred or to which referral transfer is contemplated for the purpose of facilitating continuity of the patient's health care, and

(c) any independent auditors hired or retained by any and all third party payors, private health insurers and or any employer providing health insurance benefits to the patient, applicable to the patient's office visit, for the purpose of enabling these independent auditors to analyze charges made for services rendered to the patient.

(d) The release authorization shall be effective only so long as is necessary to accomplish the purpose for which it is given. With respect to substance abuse information (if any), this consent may be revoked at any earlier time unless LFHC has release information in reliance upon it.

4. ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign, transfer and set over unto Ladies First Health Care as its interest may appear all benefits now due or becoming due to me by virtue of the present office treatment.

5. AGREEMENT TO PAY FOR SERVICES

I understand that I am liable and responsible for any health insurance deductibles and coinsurance portions of my bill. I also understand that I am responsible to pay for all services to be rendered to the patient whether signing as an agent or as patient.

6. AGREEMENT TO SURESCRIPTS

I understand and consent to Ladies First Health Care viewing and utilizing my prescription history via Surescripts for the purpose of making future medication prescriptions and coordinating prescriptions with my other providers to minimize drug-to-drug reactions and over prescribing.

The undersigned certifies that (s)he has read the foregoing or that it has been read to him/her, and that (s)he understands the same and consents thereto, and that (s)he is the patient or the duly authorized representative or agent of the patient to sign this form and consent thereto.

I further understand that my treatment may require more than one occasion of service, therefore, this consent shall carry full force and effect from the date of signature until I am discharged from further treatment.

I further understand and acknowledge that an HIV test may be performed upon myself, and in cases of birth, my child/children, without written consent in the event that a health professional, other health facility employee or emergency first responder (as defined in Act 419 of 1994) sustains a percutaneous mucous membrane, or open wound exposure to my, or in cases of birth, my child/children's blood or other body fluids.

____ Signature of Patient or Legal Representative

____ Relationship, if other than patient

______________________________________ Signature of Witness

____ Date

If patient is unable to sign, or is a minor, complete the following.

Patient is: 1.) a minor _______ years of age OR 2.) is unable to sign because ____

Revised 01/01/2022