NOLA OB GYN
Women's Health Clinic

Patient Consent Form

A. Consent for Examination and Treatment: I hereby authorize the providers and employees of Nola Ob Gyn to provide medical treatment/services which includes, but is not limited to, performing and administering tests and diagnostic procedures that are deemed necessary, including, but not limited to, imaging examinations, blood tests and other laboratory procedures as may be required by the clinic, or may be ordered by my physician(s) or persons working under the general and/or special instructions of my physician(s).

1. I understand and agree that this consent covers all authorized persons, including but not limited to residents, nurse practitioners, physicians' assistants, specialists, consultants and independently contracted physicians who are called upon by the physician in charge to carry out the diagnostic procedures and medical or surgical treatment.
2. I hereby authorize Nola Ob Gyn to retain or dispose of any specimens or tissue, should there be such remaining from any test or procedure.
3. I hereby authorize and give consent for Nola Ob Gyn providers and employees to take photographs, images or videotapes of such diagnostic, surgical or treatment procedures of patients as may be required by Nola Ob Gyn or as may be ordered by a physician.
4. 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 outcome of any tests, procedures or treatment.

B. Authorization for Release of Information: I understand that my insurance company and/or their agents may need information necessary to make determinations about payment/reimbursement. I hereby provide authorization to release to all insurance companies, their successors, assignees, other parties with whom they may have contracted, or others acting on their behalf, that are involved with payment for any hospital and/or clinic charges incurred by the patient, any information that they request and deem necessary for payment/reimbursement, and/or quality review. I further authorize the

release of my health information to physicians or other health care practitioners on staff who are involved in my health care now and in the future, and to other health care providers, entities, or institutions for the purpose of my continued care and treatment, including referrals.

C. Medicare Patient's Certification and Authorization to Release Information and Payment Request: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

REGISTRATION AUTHORIZATION

Nola Ob Gyn Clinic

D. Assignment of Insurance Benefits: I hereby authorize all insurance companies, health plans, defined benefit plans, health insurers or any entity that is or may be responsible for payment of my medical expenses to pay all clinical and medical benefits now due, and to become due and payable to me under any hospital or clinic benefits, sick benefits, injury benefits or any other benefit for services rendered to me, including Major Medical Benefits, direct to Nola Ob Gyn and all independently contracted physicians. I assign any and all rights that I may have against any and all insurance companies, health plans, defined benefit plans, health insurers or any entity that is or may be responsible for payment of my medical expenses, including, but not limited to any right to appeal a denial of a claim, any right to bring any action, lawsuit, administrative proceeding, or other cause of action on my behalf. I specifically assign my right to pursue litigation against any and all insurance companies, health plans, defined benefit plans, health insurers or any entity that is or may be responsible for payment of my medical expenses based upon a refusal to pay charges.

E. Valuables: It is understood and agreed that Nola Ob Gyn is not liable for the damage to or loss of any money, jewelry, documents, dentures, eye glasses, hearing aids, prosthetics, or other property of value.

F. Computer Equipment: I understand and agree that should I choose to use computer equipment owned by Nola Ob Gyn or if I choose to access the Internet via Nola Ob Gyn network, I do so at my own risk. Nola Ob Gyn is not responsible for any damage to my computer equipment or to any damages of any type that might arise from my loss of equipment or data.

G. Acceptance of Financial Responsibility: I agree that in consideration of the services and supplies that have been or will be furnished to the patient, I am hereby obligated to pay all charges made for or on the account of the patient according to the standard rates (in effect at the time the services and supplies are delivered) established by Nola Ob Gyn, including its Patient Financial Assistance Policy to the extent it is applicable. I understand that I am responsible for all charges, or portions thereof, not covered by insurance or other sources.

H. Communication Authorization: I hereby authorize Nola Ob Gyn and its representatives, along with any billing service or collection agent who may work on their behalf, to contact me on my cell phone and/or home phone using prerecorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication. This includes, but is not limited to, appointment reminders, yearly annual exam reminders, preventive care reminders, patient campaigns, welcome calls, and calls about account balances on my account or any account on which I am listed as a guarantor. I understand I have the right to opt out of these communications at any time.

I. Relationship Between Facility and Physician: The patient is under the care and supervision of his/her attending physician, and it is the responsibility of the facility and its nursing staff to carry out the instructions of such physicians. It is the responsibility of the patient's physician/designee to obtain the patient's informed consent, when required, for medical treatment, special diagnostic or any other procedures, or clinical services rendered for the patient under the special instructions of the physician/designee.

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J. Notice of Privacy Practices: I acknowledge I have received a copy of Nola ObGyn Privacy Practices.

K. Facility Directory: I have discussed with the organization my desire to be either included or excluded in the facility directory. I understand that if my choice is to opt-out of being identified in the facility directory that the facility will not provide any information about me such as my condition (e.g. fair, stable, etc.) or my location in the facility (e.g. room number, department).

L. TERM: This authorization is valid for this and subsequent care/treatment I receive at Nola ObGyn and will remain valid unless/until revoked in writing by me.

Witness Signature

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Printed Name *Date*

Nola Ob Gyn complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.