RESPONSIBLE PARTY (if other than patient)

NAME_____RELATIONSHIP_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE #_____CELL PHONE#_____EMPLOYER_____

SOCIAL SECURITY #_____DATE OF BIRTH_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____INSURED'S NAME_____

SECONDARY INSURANCE_____INSURED'S NAME_____

CONSENT FOR TREATMENT

The undersigned hereby consents to the furnishing of any and all examinations, treatments, procedures, laboratory procedures, drug and supplies to the patient as ordered or requested by the patient's physician and acknowledges that no guarantee or assurance has been made as to the results of such treatments, procedures, or examinations.

SIGNATURE_____DATE_____

IMPORTANCE NOTICE REGUARDING ADDITIONAL CHARGES FOR LABS

There may be additional billing for labs that was not on your original visit. If you had a pap smear or other labs that has to have additional readings you **WILL BE BILLED AT A LATER DATE THAN YOUR ORIGINAL DATE OF SERVICE.** The undersigned consents to additional billing if necessary.

SIGNATURE_____DATE_____

NOTICE OF RECEIPT OF HIPPA PRIVACY PRACTICES FOR ADVANCED OBSTETRICS & GYNECOLOGY,PC

I hereby certify that I have reviewed a copy of the **HIPPA** Privacy Practices of Advanced Obstetrics & Gynecology, PC. If you would like a copy of this for your records please see the receptionist.

PATIENT SIGNATURE_____DATE_____

WITNESS_____DATE_____