

SWOR WOMEN'S CARE

Gynecology • Obstetrics • Infertility • UroGynecology

G. Michael Swor, MD, FPMRS
Kelly-Anne Shedd-Hartman, DO, FACOOG
Jenny Lichon, DO
Holly Jackson, CNM
Allison Smith, APRN
Samantha McCormick, APRN
Gretchen Sciarrino, APRN

Dear Patient,

Thank you for choosing Swor Women's Care for your Obstetrical and Gynecological needs.

This letter confirms your upcoming appointment at Swor Women's Care.

All new patients to Swor Women's Care must arrive 15 minutes before your scheduled appointment time for registration.

Please bring any medical records that pertain to Gynecology, especially surgical reports, testing or imaging with you to your appointment. If you cannot obtain copies of your records, it may delay your treatment.

Please bring a photo identification and insurance card to each appointment.

New Patients: Please complete all paperwork mailed to you. Paperwork may be returned to us by mail, fax and/or brought to the office.

Please call us if you have any questions or need to cancel or reschedule your appointment.

It is very important that you call our office at least 24-48 hours prior to your appointment to cancel your appointment. If our office is not notified in advance, there will be a "No Show" fee of \$25 billed to your patient account.

Sincerely,

Swor Women's Care
1900 S. Tuttle Ave
Sarasota, FL 34239
Phone: 941-330-8885
Fax: 941-906-8774

Your Home for Women's Health
1900 South Tuttle Avenue Sarasota, Florida 34239
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PATIENT'S INFORMATION

(Please Print)

Today's Date: / /

Last name:		First:		M.I.	
Birth Date: / /		Age:		Marital Status: Single Married Divorced Seperated Widow	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Street Address:				Email Address:	
City:		State:		Zip Code:	
Home Phone:		Cell Phone:		Work Phone:	
How did you hear about our office?		<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other	
Race: <input type="checkbox"/> African American/ Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/ White <input type="checkbox"/> Pacific Islander/ Native American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Other					
Ethnicity: <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Non Hispanic or Latino			Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other		

PHARMACY INFORMATION

Pharmacy:	Location:
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INSURANCE INFORMATION

(Please give your Insurance card and photo identification to the receptionist)

Primary Insurance:	Secondary Insurance:
Policy Holder Name:	Policy Holder Date of Birth:

IN CASE OF EMERGENCY

Name of local friend or relative:		
Home Phone:	Work Phone:	Relationship to patient:

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

May we leave a message at your home? <input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message on your cell? <input type="checkbox"/> Yes <input type="checkbox"/> No
May we send a yearly recall to your home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do we have consent to text your cell? <input type="checkbox"/> Yes <input type="checkbox"/> No

I authorize Swor Women's Care to speak with _____
 regarding my healthcare/PHI. (relationship to patient):

I acknowledge and agree to adhere to the Notice of Privacy Practices as required by federal and state guidelines. I have been provided a copy of the Notice of Privacy Practice and understand that I may request and review a copy of these Practices at any time from the office staff. I permit the release of any information, including my medical records that may be requested by my insurance company to process any claims.

Patient Signature:	Date: / /
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CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I have completed this form and certify that I am the patient or duly authorized agent of the patient. I authorize the providers of Swor Women's Care to provide medical care and treatment for me. I authorize Swor Women's Care to obtain verification of my medication/prescription history in order to provide continuity of care. I authorize release of my medical information as directed by my physician for outside referrals to specialists, hospitals, laboratories and others as necessary for my continued care.
 I hereby authorize payment of benefits to be made directly to Swor Women's Care and/or any of the providers individually. I understand, as the recipient of services, regardless of insurance coverage, that I am ultimately responsible for payment within 30 days of the date of service or statement and billing fee may be assessed.

Patient Signature:	Date: / /
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Financial and Office Policies

We would like to thank you for choosing Swor Women's Care as your women's health care provider. This document explains our current office and financial policies. It is important that you read and agree to these policies.

Financial Responsibility: Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. For minors, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred.

Payment Form: Swor Women's Care accepts Cash, Personal Checks, MasterCard, Visa, and Discover Cards as payment for services rendered.

Insured Patients: Please bring your insurance card with you to your appointment. If your insurance plan requires an office visit co-pay, this will be collected at the time of service. The co-pay cannot be waived by our office; it is a requirement placed on us by your insurance carrier. You are financially responsible for any co-insurance, deductible or non-covered service. If you are a member of a health plan that Swor Women's Care participates with, we will submit a claim to your primary insurance company on your behalf. If you have an insurance plan that we are not providers of, payment is due at the time of service and we will assist you in submitting your claim for reimbursement to your insurance company.

Authorizations: If your insurance requires authorization for office visits, then it is your responsibility to obtain this from your primary care physician.

Balance Due: Once we have received payment along with an Explanation of Benefits (EOB) from your insurance plan, you will receive a statement from our office indicating what your insurance has paid. Any remaining balance will then be due and payable. Patients with large deductibles will be asked to pre-pay a portion of their known medical expenses (for example: GYN surgery patients)

Non Insured Patients: Payment in full will be due at the time of service. If you are unable to pay your balance in full, you will need to make arrangements with our Office Manager prior to your visit.

Medicare Patients: You are personally responsible for your deductible, co-insurance and any service that Medicare deems as "Medically Unnecessary". Medicare patients may also be asked to sign an Advanced Beneficiary Notice (ABN) form as required by Medicare for certain services.

In Office Labs/Testing: Please verify your benefits with your insurance company prior to having any lab or diagnostic testing performed. If your insurance company does not cover screening lab tests, we do offer certain tests at a reduced cost to you if performed in our office on a cash-pay basis.

No Show: Please be aware that our office charges \$25 if you no show for your appointment or if you do not give a 24-hour notice of cancellation. Also, there is a \$250 charge if you cancel or no show for a surgery with our office.

Returned Checks: A \$25 fee will be assessed for any check returned for insufficient funds. After that, only cash or credit cards will be accepted for payment.

Collection Accounts: Swor Women's Care reserves the right to turn an account over to collections if it is deemed that the account is in default of payment or compliance with this policy and you will be discharged from the practice. You can avoid collections and discharge from the practice by arranging a payment plan with the office.

Financial Hardship: We understand that sometimes it is a hardship to pay your medical bills timely. Please discuss with our Office Manager so we can work out a payment plan. Ignoring medical bills is not advisable. Let us know your situation so we can work with you.

I hereby authorize Swor Women's Care as a holder of medical information, to release to my insurance carrier or its intermediaries any information needed for this or future related claim(s). I further request payment be made to Swor Women's Care and authorize Swor Women's Care to submit claims on my behalf for any bills or services furnished to me during the next 12 month period(year). I hereby acknowledge and understand that I am financially responsible for any portion of my bill not covered by my insurance carrier. If this account is placed in the hands of a collector or an attorney for collection, reasonable cost of collection including attorney fees will be paid by the undersigned.

I have read and understand the handout, Financial and Office Policies. By signing below, I am stating that I understand and agree to the above policies. I also understand that at any time our financial policy may be updated.

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change the notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or other health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I, _____, give Swor Women's Care permission to release private health information and test results to the person(s) listed below, in the event that I am unreachable.

Name	Relationship
_____	_____
_____	_____
_____	_____

Patient Name (please print) _____

Patient Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____

Initials _____

Reason _____

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GYN Patient History Form

Today's Date: _____ Your Age: _____ Date of Birth: _____
 Patient's Name (Last): _____ (First): _____ (M.I.): _____
 Marital Status: _____ Cultural Identity: _____
 Height: _____ Weight: _____

How did you hear about Swor Women's Care? _____
 Are you here for a Gyn Annual Exam? Follow up? Problem? Consultation? Other?: _____

Allergies/ Reactions: _____
 Current Medication (include over the counter medications, vitamins and dosages): _____

Other Physicians: _____

Current Problems

(If you currently have or do not have these problems, Please circle Yes or No)

Abnormal or Unexpected bleeding?	Y/N	Abdominal or pelvic pain?	Y/N
Hormonal Problems?	Y/N	Vaginal Discharge?	Y/N
Unusual Breast Symptoms?	Y/N	Vaginal Irritation?	Y/N
Pressure in Pelvic Area?	Y/N	Genital Lesions?	Y/N
Difficulty emptying bladder or bowels?	Y/N	Changes in Bladder or Bowel Functions?	Y/N
Any other women's health issues?	_____		

Obstetrical History

Have you ever been pregnant Y/N History of Infertility? Y/N

Number of Pregnancies?	Full Term or Pre-Term?	Number of Abortions?	Number of live births?	Number of miscarriages?	# of tubal/ectopic pregnancies?	Number of C-Sections?

Current Birth Control Method

☐ Rhythm Method
☐ Condoms
☐ Diaphragm, Sponge, or Suppository
☐ Oral Contraceptives
☐ Transdermal Patch
☐ Vaginal Ring
☐ Depo Provera
☐ Intrauterine Device
☐ Vasectomy
☐ BTL (Tubal Sterilization)
☐ None

Menstrual History

Periods are _____ days part
 Menstrual bleeding usually lasts _____ days
 Are your periods abnormal? Y/N
 Date of last period? _____
 Age of first period? _____
 Age menopause occurred? _____

Sexual History

Are you sexually active? Y/N
 Are you in a monogamous relationship? Y/N
 Are you in a same sex relationship? Y/N
 Are you in a opposite sex relationship? Y/N

Health Habits

Are you knowledgeable about and practice good nutrition? Y/N
 Are you knowledgeable about and practice regular exercise? Y/N

Drugs and Alcohol

Past legal or illegal drug use? Y/N
 Current legal or illegal drug use? Y/N
 Do you drink alcoholic beverages? Y/N
 How many drinks per week? _____

Smoking History:

Current Past Never Quit

Safety

Have you been involved in domestic abuse in the past 12 months? Y/N
 Have you suffered abuse in the past? Y/N
 Do you live in a safe environment? Y/N

Past Medical History

Mark X if positive	Medical Problem	Year Started	Resolved Y/N	Mark X if positive	Medical Problem	Year Started	Resolved Y/N
	Cardiac Workup				Arthritis		
	Heart or Blood Vessels				Acne		
	Premature Cardiovascular Disease				Skin Cancer(Squamous, Basal Cell, Melanoma)		
	Coronary Artery Disease				Interstitial Cystitis		
	Hypertension (high blood pressure)				Recurrent UTI		
	Deep Venous Thrombosis				Kidney Stones		
	Valvular Heart Disease				Chronic Renal Disease or Insufficiency		
	Diabetes Mellitus				Amenorrhea		
	Thyroid disorder				Anovulation		
	Ear, Nose and Throat				Endometriosis		
	Viral Hepatitis				Fibroids in the Uterus		
	Easy Bleeding				Osteopenia		
	Hepatitis (chronic)				Osteoporosis		
	Chronic Colitis or Crohns				Pelvic Inflammatory		
	GERD (esophageal reflux,ulcers)				Chlamydia		
	Cholelithiasis (gallstones)				Warts (genital)		
	Hernia				HPV		
	Diverticulosis or Diverticulitis				Herpes (HSV)		
	Irritable Bowel Syndrome				Cervical Dysplasia		
	Hyperlipidemia				PCOS (Polycystic Ovaries)		
	Obesity				Ovarian Cancer		
	Migraine Headaches				Hereditary Cancer Syndrome		
	Epilepsy and Recurrent Seizures				Breast Cancer		
	Bones, Fractures, and Joints				Cervical Carcinoma		
	Anxiety Disorder				Vulvar Carcinoma		
	Depression				Endometrial Carcinoma		
	Bipolar Disorder				Ovarian Cyst		
	Asthma				Colon Cancer		
	Chronic Obstructive Pulmonary Disorder				Colon Polyps		
	Autoimmune Disease				History of Malignancy		

Surgical History

X if Yes	Year	Surgery	X If Yes	Year	Surgery
		D&C Hysteroscopy			Hysterectomy (Cervix intact or removed)
		Endometrial Ablation			Appendectomy
		Laparoscopy (diagnostic or operative)			Cholecystectomy (gallbladder removal)
		C-Section			Breast Surgery
		Leep or Cone Biopsy			Lap Band- Gastric Bypass
		Tubal Sterilization			Colectomy for Tumor
		Ovarian Cystectomy			Hemorrhoidectomy
		Salpingo Oophorectomy			Hernia Repair
		Ectopic Pregnancy Surgery			Fracture(s)
		Pelvic Floor Repair			Joint Replacement
		Sling or Surgery for Incontinence			

Other Past Surgery and Date

Family History

Condition	Affected Member	Age Diagnosed
GYN Cancer(Uterine, Ovarian, Cervical)		
Breast Cancer		
Colon Cancer		
Melanoma		
Heart Disease		
Hypertension		
Stroke		
Osteoporosis		
Diabetes Mellitus		
Alzheimer's Disease		
Thromboembolic Disease		
Other Cancer or Major Disease		

About You As A Person

Tell us about your cultural background?	
What is your racial background?	
Place of Birth? Hobbies?	
Occupation?	
What is your educational background?	
Describe any major life changes recently?	
Describe any recent emotional stress?	

Previous Tests and Screening

X If Yes	Month/Year of most recent	Testing/Screening	X If Yes	Month/Year of most recent	Test/Screening
		Pap Smear			Cervix Cryosurgery
		Colonoscopy			Cervix Laser Cone Excision
		GYN Ultrasound			Vaginal Biopsy
		Mammogram			Vulvar Biopsy
		Breast Ultrasound			Endometrial Biopsy
		Bone Density			Urodynamics
		Colposcopy			Sonohysterogram
		LEEP or Cone Biopsy			Blood Transfusion

Review of Systems

*(If **YOU** have had any of these conditions **in the last year**, Please indicate with X)*

X If Yes	How Long	Condition	X If Yes	How Long	Condition
		Weight Gain			Blood in Urine
		Fever			Genital Lesions
		Feeling Tired			Other Genitourinary Symptoms
		Other Constitutional Symptoms			Skin Lesions
		Head or Sinus Symptoms			Change in Mole or Non-healing Sore
		Eye Symptoms			Other Skin Symptoms
		Ear, Nose and Throat Symptoms			Endocrine Symptoms
		Neck Symptoms			Hormonal Symptoms
		Breast Related Symptoms			Musculoskeletal Symptoms
		Cardiovascular Symptoms			Neurological Symptoms
		Pulmonary Symptoms			Sleep Disturbances
		Gastrointestinal Symptoms			Anxiety
		Pain with Urinating			Depression
		Increased Urinary Frequency			Other Psychological Symptoms

Thank you for your help in collecting useful and important information for your permanent electronic records. We are trying to streamline the entry of medical data, and make it easier to share and update as you instruct us to.



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PLEASE READ INFORMATION VERY IMPORTANT

Medicare Annual Gynecological Exam

Medicare decreased certain benefits to women in January 2011. These new rules have put more payment responsibility on patients. Annual Wellness visits performed by your primary care provider and are geared toward addressing ongoing medical problems, a personalized prevention plan, and counseling unrelated to gynecology. Some of the services you normally receive in our office (pap smear, pelvic exam, and breast exam) are NOT included in this Annual Wellness visit.

As always, we recommend Annual Gynecological Exams/ Women's Health Visit for our patients, including those covered by Medicare. Guidelines for certain tests change from time to time. We recommend a pelvic exam, breast exam, and colorectal cancer screening exam every year. We advise pap testing on a schedule individual to each patient although Medicare only reimburses for pap testing every two years. Your yearly visit also provides you with guidance of testing, prescriptions and women's health advice through our office. Medicare will pay a portion of your Gynecological Annual Exam every 24 months. New Medicare rules from our government programs do not cover your expenses as well as in the past. The screening portion of the yearly exam is not a covered benefit anymore and patients are now responsible for that \$58.00 charge at the time of service. The Women's Health Exam, along with the collection of the pap smear, will be billed to Medicare, and may be covered every 2 years if you meet the guidelines, applicable copays and deductibles.

If you have any questions, please call our office at 941-330-8885

I have read the information above and understand that insurance may not cover the full exam.

Signature: _____

Date: _____

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A. Notifier: Swor Women's Care

B. Patient Name: C. DOB:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. Services** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. Services** below.

D. Services	<input type="checkbox"/> Preventative Exam <input type="checkbox"/> Breast/Pelvic Exam <input type="checkbox"/> Pap Smear <input type="checkbox"/> Fecal Occult Testing	<input type="checkbox"/> Not covered by Medicare <input type="checkbox"/> Covered every 24 months <input type="checkbox"/> Covered every 24 months <input type="checkbox"/> Covered every 12 months
E. Reason Medicare May Not Pay:	Medicare does not pay for these tests as often as ordered for you.	
F. Estimated Cost	Preventative Exam Pelvic & Breast Exam \$41 Pap Smear Collection \$44 Fecal Occult Testing	\$58 \$41 \$44 \$18

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Services** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- ☐ **OPTION 1.** I want the **D. Services** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- ☐ **OPTION 2.** I want the **D. Services** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- ☐ **OPTION 3.** I don't want the **D. Services** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
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CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



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LABORATORY TESTING

Swor Women's Care will be sending all in house specimen collections to Florida Woman Care Laboratory, LLC for interpretation. If they are not contracted with your insurance, they will forward to correct lab facility.

Florida Women Care Laboratory, LLC is a laboratory dedicated solely to women's healthcare, which we believe will provide our patients with a high level of specialized care for laboratory testing. The group's laboratory employs only Pathologists with specialty expertise in Gynecological Pathology and/or Cytopathology to ensure high quality, specialized testing and analysis. In addition, our physicians will have a direct line of communication with these pathologists to discuss your care.

We believe these factors will contribute to our ability to provide our patients with increased continuity of care and more timely results. As with any laboratory and its services, we cannot guarantee that all services will be covered at 100% under each patient's insurance plan. If the labs ordered are subject to your deductible, co-pay, co-insurance, and in some cases not covered by insurance you will receive a separate lab bill for any/or all tests that were ordered by the provider.

Self-pay patients, any extra charges, such as labs, tests and or/procedures need to be paid prior to leaving the office to take advantage of the discount. All self-pay rates are discounted from our billed charges and not included with our office fees.

We do appreciate the opportunity in taking care of you and your family.

Print Patient Name

Date of Birth

Patient Signature

Date

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Consent for Pelvic Examination

According to The American College of Obstetricians and Gynecologists, the pelvic examination is part of the evaluation of women presenting with many common conditions, including pelvic pain, abnormal bleeding, vaginal discharge, and sexual problems. Pelvic exams—both in the office and while under anesthesia— are also an important part of evaluation for gynecologic procedures to ensure safe completion of the planned procedure. Often, a pelvic examination is performed for women without symptoms while looking for gynecologic cancer, infection, and pelvic inflammatory disease.

A pelvic examination is an assessment of the external genitalia; internal speculum examination of the vagina and cervix; bimanual palpation of the adnexa, uterus, and bladder; and sometimes rectovaginal examination. Reasons for a pelvic exam can include (but are not limited to) health screening, abnormal bleeding, pelvic pain, sexual problems, vaginal bulge, urinary issues, or inability to insert a tampon. Other indications include patients undergoing a pelvic procedure (e.g., endometrial biopsy or intrauterine device placement). Also, pelvic examination is indicated in women with current or a history of abnormal pap results, gynecologic cancers, or toxic exposures.

The potential benefits of a pelvic examination include the detection of vulvar, vaginal, cervical, uterine and ovarian cancers and precancers, yeast and bacterial vaginosis, trichomoniasis, and genital herpes, early detection of treatable gynecologic conditions before symptoms begin occurring (e.g. vulvar or vaginal cancer), as well as incidental findings such as dermatologic changes and foreign bodies. Additionally, screening pelvic examinations in the context of a well woman visit may allow gynecologists to explain a patient's anatomy, reassure her of normalcy, and answer your specific questions.

The potential risks of a pelvic exam may include (but are not limited to) fear, anxiety, embarrassment (reports ranged from 10% to 80% of women) or pain and discomfort (from 11% to 60%).

There are few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluative information and carry their own set of potential risks. If you have concerns, you should discuss with your healthcare provider.

I _____ understand that this Patient Consent Form is required by law. I understand that I need to sign this form to show that I am making an informed decision to have pelvic examinations and I have read and understand the above.

The provider or their delegate has explained to me the nature, purpose, and possible consequences of each procedure as well as risks involved, possible complications, and possible alternative methods of treatment. I also know that the information given to me does not list every possible risk and that other, less likely problems could occur. I was not given any guarantee from anyone about the final results of this procedure.

Signature / / / /
DOB Date

I understand that my provider is involved in educating tomorrow's medical professionals and that familiarizing students with the female anatomy and instilling a physician workforce with confidence in pelvic examination skills is essential. I consent to pelvic examination by the medical professional student under the supervision of my medical provider.

_____/_____/_____
Signature Date