ALL ABOUT WOMEN OBGYN
70 Doctors Drive Panama City, FL. 32405
Office: 850-785-1517, Fax: 850-784-1271 web: www.aawob-gyn.com
Stephen G. Smith, M.D., Tricia M. Percy, D.O., Roslyn V. Mallory, M.D.
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Tammie Y. Mott, CNM, C. Michelle Sims, CNM, Kassie S. King, CNM

Date_____

Marital Status Single_____ Married_____ Widow_____ Divorced_____ Race_____

Patient's Full Name_____ Preferred Name_____

Birthdate_____ Social Security #_____

Mailing Address_____Apt#_____

City, State, Zip Code_____

Cell/Home Number_____ Work Phone_____

Email_____

Name of Primary INSURANCE Carrier _____

Contact/ID/Policy # _____ Group# _____

Subscribers Name _____Relationship to Patient _____

Subscriber's Date of Birth _____ Subscriber's Social Security# _____

Secondary Insurance _____

Policy Holder's Name _____ Relationship to Patient _____

Contact/ID/Policy # _____ Group# _____

Subscribers Name _____Relationship to Patient _____

Subscriber's Date of Birth _____ Subscriber's Social Security# _____

Husband's Employer & Phone # _____

I authorize the release of any medical information necessary to process insurance claims for payment to All About Women OBGYN **I understand that if I am not eligible under the terms of my medical and hospital health insurance, I am liable for all charges for services rendered and I agree to pay all costs associated with my account if placed for collection**. Accounts are considered delinquent and will be placed for collection if not paid in full within 90 days of date of service.

SIGNATURE_____

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Consent For Treatment

I request those physicians and other healthcare professionals who care for me at the practice to perform/order appropriate laboratory/diagnostic procedures and provide therapeutic treatments, which in the judgement of my physician or other healthcare professionals are medically necessary in the course of my medical treatment or preventative care. I also understand that it is the policy of this practice to perform urine testing on patients when appropriate, including urine pregnancy testing on every patient of childbearing age unless they have had a complete hysterectomy.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made or will be made to me as to the results of any processional services that may be received by me as a patient of the practice; i.e. treatments, examinations, procedures, etc. I authorize my provider to retain, preserve and use for scientific or educational purposes, or dispose of at their convenience, any specimens or tissue taken from my body during a visit. If I undergo any procedure that requires submission of tissue for pathologic examination, I authorize the use of any excess tissue for education purposes.

I consent to telephone, synchronous audio-visual or digital communication with my physicians and other healthcare professionals at the practice as an alternative to a face-to –face visit to provider care or treatment.

I certify that I have read this form and understand its contents

Signature_____Date_____

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by All About Women OBGYN, or disclosed to others for the purpose of treatment, or obtaining payment to support operations of the practice.

Notice of Privacy Practices
You should review the **Notice of Privacy Practices** for a more complete description of how your protected health information may be used or disclosed and it is available on request.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use of disclosure of your protected health information.

All About Women OBGYN may or may not agree to restrict the use or disclosure of your protected health information.

If All About Women OBGYN agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
All About Women OBGYN reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and give my permission to All About Women OBGYN to use and disclose my health information in accordance with the **Notice of Privacy Practices.**

PLEASE LIST ANY PERSON(S) YOU WOULD LIKE TO RELEASE YOUR MEDICAL INFORMATION

NAME_____RELATION_____PHONE_____

NAME_____RELATION_____PHONE_____

NAME_____RELATION_____PHONE_____

NAME OF PATIENT (PRINT) DATE

SIGNATURE OF PATIENT DATE

*****A PARENT/PATIENT REPRESENTATIVE IS NEEDED ONLY IF THE PATIENT IS A MINOR, OR NOT PHYSICALLY OR MENTALLY COMPETENT TO SIGN FOR THEMSELVES*****

_____

SIGNATURE OF PARENT/PATIENT REPRESENTATIVE DATE

_____

RELATIONSHIP OF PATIENT REPRESENTATIVE

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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 eternal 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 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 result of this procedure.

_____ _____

Signature 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 examinations skills is essential I consent to pelvic examination by the medical professional student under the supervision of my medical provider.

_____ _____

Signature Date