



TURNINGPOINT WOMEN'S HEALTHCARE, INC.

Patient Name: _____ MR# _____

CONSENT TO EVALUATE/INITIATE TREATMENT

I do hereby consent to the evaluation and initiation of treatment by TurningPoint Women's Healthcare, Inc.

Patient/Responsible Party Signature _____ **Date** _____

Witness Signature _____ **Date** _____

TERMS FOR TREATMENT

I understand that payment is due at time of service. TurningPoint Women's Healthcare, Inc. generally files insurance as a courtesy to its patients. However, if there is an outstanding deductible or a co-pay due, I understand that this amount is payable at the time of service. I further understand that if my insurance does not pay within 60 days of the date of service, I will be responsible for the balance of the charges due, with payment made or acceptable payment arrangements made in writing within 30 days. I understand that I am totally responsible for payment of all fees for services rendered, irrespective of insurance coverage or other responsible parties (subject to the rules of Medicare reimbursement).

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize TurningPoint Women's Healthcare, Inc. to release information from my medical records, whether it be written, video, photographic, audio, or verbal, to any third party payer (such as an insurance company or government agency), or any person employed by such carrier for the purpose of collecting insurance benefits. This authorization includes release of information to employers for group insurance coverage, worker's compensation carriers, and welfare agencies, if applicable to my claim for treatment. I hereby indemnify and release this practice from any and all responsibility relative to release of such information.

I assign direct payment to this practice of all benefits payable which are applicable to my treatment and grant this practice Power of Attorney in the collection of benefits. This assignment is applicable to all future charges and fees from, and including, this day forward, unless otherwise revoked by me in writing.

FOR MEDICARE PATIENTS ONLY: I request that payment of authorized Medicare benefits be made on my behalf to TurningPoint Women's Healthcare for services rendered by them. I authorize any holder of medical information about me to release to the Health Care Financing Administrator and its agents any information needed to process my claim for benefits.

I understand that if I do not have supplemental insurance coverage, or if my supplemental insurance pays me directly, I will be responsible for the 20% co-insurance portion not paid by Medicare, as well as any deductible.

Signature _____ **Date** _____
