ACCOUNT: _____

SWC Stark Women's Center Obstetrics and Gynecology

DATE: _____

PLEASE VERIFY ALL INFORMATION AND MAKE CORRECTIONS WHERE NEEDED

PATIENT NAME: _____

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

TELEPHONE: (____) _____ **CELL PHONE:** (____) _____ **WORK PHONE:** (____) _____

BIRTH DATE: _____ **AGE:** _____ **SS#** _____ - _____ - _____

PATIENT EMPLOYER: _____ **ADDRESS:** _____

SPOUSE/GUARDIAN: _____ **SS#** _____ - _____ - _____

BIRTH DATE: _____ **EMERGENCY NAME & PHONE:** _____

PREFERRED PHARMACY NAME & PHONE: _____

PRIMARY CARE PHYSICIAN: _____

E-MAIL ADDRESS: _____

IF YOU NEED A REFILL ON YOUR PRESCRIPTION CALL OUR OFFICE.WE DO NOT ACCEPT ANY OTHER REFILL REQUEST METHODS FROM PATIENTS AND WE DO NOT ACCEPT REQUESTS FROM PHARMACIES.

PARTY(S) RESPONSIBLE FOR PAYMENT FOR SERVICES AND/OR SUPPLIES RENDERED AND PROVIDED TO PATIENT:

_____ SIGNATURE OF PATIENT (IF NOT A MINOR)

_____ SIGNATURE OF ADDITIONAL RESPONSIBLE PARTY PARENT/GUARDIAN

I hereby authorize **Stark Women's Center,** to furnish information to insurance carriers concerning my care, and I hereby assign the physician(s) all payment for medical services rendered to myself.

I also hereby authorize and give permission to my attending physician, and other health professionals associated with my physician, to discuss my medical or other relevant information with my physician's professional advisors and billing agents, as may be deemed necessary by my physician. A copy of this authorization shall be considered as valid as the original.

_____
Patient's Signature

1 As the patient of **Stark Women's Center**, I realize that I have the right to make decisions regarding my care and treatment. Throughout my care, **Stark Women's Center**, will discuss with me any condition I may have, including what may happen if such condition is not treated. We will also discuss different treatments, and the pros and cons of each.

Stark Women's Center, believes that certain treatments and/or procedures may at some time during my care become medically necessary. **Stark Women's Center**, believes that the appropriate standard of medical care requires the use of blood transfusions and the use of blood byproducts. I understand the possible need for such treatment and agree that if, in my physician's medical opinion,it becomes necessary, it may be performed.

I realize that if the situation arises in which my physician believes that any of the above treatments and/or procedures are medically necessary, **Stark Women's Center**, will discuss my condition with me, including my physician's medical reason for the need of the procedure and what may be accomplished by the treatment or procedure. At that time I will be given the opportunity to give consent to the treatment, and to ask questions about the treatment and/or procedure and any other risks or issues that concern me.

_____
Patient's Signature

2 As a minor of the age of _____ years, I give **Stark Women's Center**., my permission that the party agreeing to be financially responsible be provided with all information regarding services rendered, treatment initiated and the results of any diagnostic or x-rays to be released.

_____ Signature of Responsible Parent or Guardian

_____ Signature of Patient