CHOICES.
Memphis Center for Reproductive Health

Name: _____
Pt#: _____
Date: _____
DOB: _____

Consent for Provision of Medical Services/ Receipt of Notice of Privacy Practices

Name: _____

Phone #: _____ Social Security #: _____

Before you consent, be sure you understand the information we have given you. If you have any questions, our staff will be happy to discuss them with you. Your consent is entirely voluntary. You may ask for and receive a copy of this form at any time.

- CHOICES is committed to protecting patient privacy. I have the right to review and receive a copy of CHOICES' privacy policy.

- I understand that information contained in my medical record is confidential. It will not be released without my written authorization, except to protect my life and health.

- I understand that I have the right to revoke this consent in writing at any time, except to the extent that action has already been taken.

- I understand that I have the right to restrict the use or disclosure of information in my medical record, and CHOICES has the right to refuse treatment if I do. If treatment is refused, a referral to another clinic or medical practitioner will be provided at my request.

- I understand that communication between CHOICES, my private physician, my pharmacy, and/or other entities may be necessary in the course of testing and treatment. I give my consent for disclosure of medically necessary information.

- I hereby request that a person authorized by CHOICES examine me, on one or more occasions, and perform any laboratory tests that may be necessary as part of my examination and treatment. I understand that a clinician is available to answer any questions I have.

- I consent to diagnostic tests, including HIV screening, and medical treatments as the practitioners of CHOICES prescribe. I understand that I must verbally inform CHOICES staff should I wish to decline any tests and treatments. If I decline medically necessary testing or treatments, CHOICES has the right to refuse to give me further medical services. If medical services are refused, a referral to another clinic or medical practitioner will be provided at my request.

- I understand that positive Gonorrhea, Chlamydia, Syphilis, and HIV results are reported to the Tennessee Department of Health as required by Tennessee state law. I also understand that CHOICES is required by Tennessee state law to report certain statistical information.

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- I understand that I will be given referrals for any further diagnosis or treatment, if necessary. I understand that if a referral is needed, I assume all responsibility for obtaining and paying for that care.

- I understand that CHOICES is required by law to report known or suspected instances of statutory rape, child abuse and neglect, and child sexual assault.

- I release CHOICES from any and all claims which I may have by reason of their providing this medical examination.

- I authorize CHOICES to collect payment for all medical services and care provided to me.

- I request authorized benefits be made on my behalf to CHOICES clinicians for any services furnished to me. I authorize any holder of medical information to release to the insurance carrier any information needed to determine these benefits payable for related services.

- I understand that I am financially responsible for all charges for services and care provided to me, not payable by insurance, including annual deductible, copayment, coinsurance, and any non-covered/cosmetic services. If I am without verified health insurance or with a plan which CHOICES does not participate, I am required to pay in full at the time services are rendered. In the event that my insurance company denies any claim or pays my claim as "out of network," I am responsible for the balance. If patient is under 18, the parent/guardian requesting services for minor accepts responsibility for payment. I understand that if my account ever requires the services of a collection agency or attorney in order to collect the balance owed, that fees incurred by these agents will be added to the balance due on my account. Collection fees will also include recovery costs (35%) of total account balance due; court costs, and judgment costs. I understand that Choices accepts cash, bank debit card, MasterCard, Visa, or money orders for payment of services.

Initials _____

By my signature below, I certify that I have read, understood, and agreed to each statement contained in this form.

Patient Signature: _____ **Date:** _____

I witness the fact that the patient received the above information, and stated s/he understood the information.

Witness Signature: _____ Date: _____