The Woman's Care Center, PC
OB/GYN

1. I _____ (patient name) give permission for **The Woman's Care Center** to give me medical treatment. I am asking for medical care and treatment at this facility and agree to accept services which may diagnose a medical condition, procedures to treat my condition and routine medical care. I have not been given any guarantees as to the results of the services I will receive.

2. I allow **The Woman's Care Center** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **The Woman's Care Center** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.
   - That my agreement to accept these services will remain in effect unless I say that I no longer want these services or until my treatment is completed.
   - That my agreement to accept these services is called a General Consent and that it includes any routine procedure(s) or treatment(s) such as blood drawing, physical examination, urine screenings, and other non-invasive procedures.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature (for children under 18) Date

_____ _____

Print name