<u>**Tri-County OB/GYN Associates**</u>
Dr. Spaulding Dr. McDanald Dr. Richardson Dr. Mann
Revised 2-7-2007

CONSENT FOR HEALTH CARE RELATED SERVICES:
I authorize medical services, as determined by my physician(s). I understand this authorization is to cover my office exam, radiology, and laboratory services. Any surgery or other procedures will have the purpose, risks, alternatives, and possible complications of treatment adequately explained to me by my physician(s) and a separate consent for those services will be required. No guarantees have been made to me as to the outcome of treatment.

AGREEMENT TO PAY:
I agree to pay Tri-County OB/GYN Associates charges for services rendered. I am financially responsible for all charges that are not paid or approved by my insurance company. I understand that all balances over 60 days old are subject to a collection fee. I authorize release of any pertinent medical information to my insurance company as requested to secure payment. Please contact your insurance company if you have any questions regarding your insurance benefits.

REFERRALS:
If required, I understand I am responsible for obtaining an insurance referral to be seen in this office. I understand that I am responsible for any charges incurred due to denied benefits if a referral is not obtained.

ASSIGNMENT / AUTHORIZATION TO PAY INSURANCE BENEFITS:
I assign to Tri-County OB/GYN Associates all expense benefits, which are due for medical services. I authorize the benefits to be paid directly to Tri-County OB-GYN Associates, PLC.

ADVANCE DIRECTIVE:
I do have a Living Will and or Power of Attorney **YES** **NO**
If yes, please notify us so we may obtain a copy for our records.

CALL US IF YOU NEED TO CANCEL AN APPOINTMENT
In our attempt to provide you with the best Obstetrical and Gynecological care, we have found it necessary to implement an attendance policy. If you can't come to an appointment, we ask that you phone us 24 hours in advance to cancel and reschedule your appointment. If we do not receive a cancellation call from you at least 24 hours in advance, or no call at all, **YOUR ACCOUNT WILL BE ASSESSED A FEE OF $50.00 FOR EACH NO SHOW**, which will need to be paid in full before your next appointment. There is no exception to this fee.

BE ON TIME FOR YOUR APPOINTMENT
If you are late for your scheduled appointment, we may not be able to treat you, or you may not receive all your services, and will need to reschedule. If you know in advance you will be late, please phone us. We will be able to let you know if you can be seen. It is very important to us and our other patients that we stay on schedule.

THREE 'NO-SHOWS' IS OUR LIMIT
If you miss appointments without contacting us three times, we will assume you are receiving care elsewhere and may not schedule further appointments for you. In order to meet the needs of the most patients possible, we must take our schedules very seriously. We will notify your primary physician if three no shows occur. To resume the treatment series, another referral from your primary care physician may be required. We thank you for your consideration in this matter. Attendance is important for good progress in your care and for efficient use of our time. We look forward to working with you.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
I have read the Practice's notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Signature of Patient____

Responsible party____

Date____________________________**Witness**____________________________