Vermont Gynecology

REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES AND CONSENT TO DISCLOSURES

DATE _____ PATIENT # _____

NAME OF PATIENT _____

DATE OF BIRTH _____ PREFERRED TELEPHONE # _____

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Vermont Gynecology may need to refer me to another health care facility to provide the services necessary for my care.

I will be given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been or will be given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Vermont Gynecology.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will have lab tests such as Pap smears, biopsies, and blood and urine tests as indicated in my care. I understand that Vermont Gynecology will bill me for the procedures that generate the tests, as well as for any tests processed on site. I am aware that most specimens are sent to outside laboratories; that those labs set the fees for such tests; and that I will receive separate bills from those outside labs. I will assume responsibility for paying for these tests. It is also my responsibility to understand what my insurance plan covers, as plans vary significantly.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Vermont Gynecology's *Notice of Health Information Privacy Practices*. I consent to and authorize the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

Please turn this page over

I hereby request that a person authorized by Vermont Gynecology provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

I hereby acknowledge receipt of Vermont Gynecology's Notice of Health Information Privacy Practices.

Signature of patient _____

Patient name (please print) _____

Date _____

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of witness _____

Date _____

	CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW

Signature of any other person consenting _____

Relationship to patient _____

Date _____

I witness the fact that the patient's legal guardian (or person consenting in her behalf) received the above mentioned information and said she read and understood same.

Signature of witness _____

Date _____