

CONTRACTED CARE CONSENT AND AUTHORIZATION FORM

Patient: _____ Responsible Party: _____
Relationship: _____

CONSENT FOR ROUTINE TREATMENT: I hereby consent to the rendering of medical care, which may include routine diagnostic procedure and such medical treatment as my physician(s) or others at Gaston Women's Healthcare consider being necessary. I understand that:

- It is the policy of Gaston Women's Healthcare that, absent emergency or extraordinary circumstances, no substantial procedures are performed upon me unless and until I have had an opportunity to discuss them with my physician(s) or other healthcare professional to my satisfaction; and
- I have the right to consent, or to refuse consent, to any proposed procedure or therapeutic course.
- **Infertility treatment:** The treatment is an inexact science. There are many contributory factors that may cause an inability to conceive. Therefore, Gaston Women's Healthcare makes o guarantee, warranty, promise, or commitment whatsoever that you will become pregnant as a result of your treatment. You hereby agree to pay any charges or fees for treatment received in connection with your infertility treatment regardless of whether you become pregnant or do not become pregnant.

PAYMENT: I/We, jointly and severally, guarantee the full and complete payment of all charges for medical care rendered by Gaston Women's Healthcare and its physician(s) to me, my spouse and/or minor children.

I/We, jointly and severally, guarantee the full and complete payment of all charges for medical care rendered by Gaston Women's Healthcare and its physician(s) to my minor child (whether living with me or not). This is a guarantee of payment and not merely of collection, and I agree to be directly responsible for the payment of all charges incurred by these children.

If I/We fail to pay and such charges due to Gaston Women's Healthcare and it becomes necessary for Gaston Women's Healthcare to institute collection efforts against me/us, I/We agree to pay Gaston Women's Healthcare all cost of collection thereof, including reasonable attorney's fees incurred in the connection therewith.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Gaston Women's Healthcare of medical or surgical benefits otherwise payable to me, including major medical insurance. I understand that I am financially responsible in the event medical or surgical benefits exceed the charges of Gaston Women's Healthcare for its services in connection with the treatment rendered during this and all future encounters. Any such excess amount may first be applied to payment of any other indebtedness due by me or my legal dependents for other treatment rendered and the balance, if any remains, shall be paid to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: Gaston Women's Healthcare and/or my physician(s) are authorized to furnish any medical information relating to treatment to my insurance company, health maintenance organization, preferred provider organization, alternative delivery system, governmental or charitable agencies and their agents, my employer, and professional review organizations with whom I have an established relationship. I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization prior to its revocation.

I HAVE READ AND UNDERSTAND THIS AUTHORIZATION FORM, AND AGREE TO THE PROVISIONS PERTAINING TO MY RELATIONSHIP WITH GASTON WOMEN'S HEALTHCARE.

(SIGNATURE OF PATIENT)	(SIGNATURE OF WITNESS)	DATE
(SIGNATURE OF PARENT/GUARDIAN)	(SIGNATURE OF WITNESS)	DATE

ALL PATIENTS UNDER 18 YEARS OF AGE MUST HAVE A PARENT OR GUARDIAN SIGN BEFORE THEY CAN BE SEEN.