4239 Farnam St. Suite 734 / (402) 552-2700
16909 Lakeside Hills Ct. Suite 201 / (402) 991-1900
Emergencies & After Hours / (402) 552-2700
Medical Record Fax / (402) 552-2972
Office Fax / (402) 552-2709

CONSENT'S OF
OMAHA OB/GYN ASSOCIATES, P.C.

CONSENT TO TREAT:
I voluntarily consent to medical treatment and diagnostic procedures by Omaha OB/GYN Associates, P.C. I consent to the testing for infectious diseases, such as but not limited to syphilis, hepatitis, HIV/AIDS, and testing for drugs if deemed advisable by my physician.

> HIV(Human Immunodeficiency Virus) is the virus that causes AIDS (Acquired ImmunoDeficiency Syndrome). A positive HIV test means that HIV antibodies have been detected, and that the individual has probably been infected with HIV. A negative test means that the antibody to HIV has not been detected, and the individual has probably not been infected with HIV.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations.

CONSENT TO E-PRESCRIBING PBM:
I hereby authorize that Omaha OB/GYN Associates, P.C. can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

ACKNOWLEDGMENT OR RECEIPT OF NOTICE OR PRIVACY PRACTICES
I acknowledge that I was provided with the Notice of Privacy Practice of the Medical Practice named at the top of this page.

AUTHORIZATION FOR RELEASE OR INFORMATION:
I hereby authorize the release of my medical records by Omaha OB/GYN Associates, P.C. to my attending physician, hospitals and third party payer (whether an insurance co., government agency, employer or self insurance employer or utilization review organization).

ASSIGNMENT OF BENEFITS:
I hereby assign to said physician all right, title and interest to any benefit payable for medical coverage. I direct that such benefits be paid directly to said physician and I will be responsible for any charges accrued and not paid by the insurance company. **I understand I am responsible for all co-pays, deductibles, co-insurance and any non-covered services.**

CONSENT FOR SHARING of PROTECTED HEATLH DATA and INFORMATION:
Please list the names and relationship of family members or other persons, if any, whom we may inform verbally and/or copy of records to about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

1._____ 2._____

Can confidential messages (i.e. appointment reminder, test results, etc.) be on your telephone answering machine or voicemail? *I am fully aware that a cell phone is not a secure and private line.*

YES_____ NO_____

_____
Patient's Name (PRINT)

_____ _____ _____
Signature of Patient or Responsible Party **Responsible Party Relationship to Patient** **Date**

For Practice Use Only: Witness
Signature of Practice Employee _____Date_____
Doctor_____ Acct. #_____