CONSENT FOR TREATMENT -This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. You have the right to discuss the treatment plan with your physician or designated provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

_____

Signature of Guardian (if patient is under 18)

_____

Printed Name of Guardian

3200 Downwood Circle, Suite 220
Atlanta, Georgia 30327www.idealgynecology.com
(470) 312-3696

IDEAL GYNECOLOGY
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Atlanta, Georgia 30327
(470) 312-3696

Lilian Schapiro, MD
Ashlee Forrester, WHNP
Kathryn Garren, WHNP

Legal Name. _____ Date of Birth. _____ SSN# _____

Race: African American ___ Native American ___ Asian __ Pac.Islander ___ White/Cauc. _____ Pat.Refused _____

Ethnicity: Hispanic or Latino _____ Non-Hispanic or Latino _____ Patient Refused _____

Home address. _____ Apt# _____

City _____ State ____ ZIP _____

Email _____ Cell phone _____

Employment: Full Time _____ Part Time _____ Self-employed _____ None _____

Employed by _____

Marital Status: Single __ Married __ Divorced ___ Widow ___ Spouse's Name _____

Person authorized to discuss care: Name _____ Relation _____ Phone _____

Emergency Contact (Living with you) Name _____ Relation _____ Phone _____

Emergency Contact (Not living with you) Name _____ Relation _____ Phone _____

Primary Care Physician _____ Phone _____

If MINOR, Responsible Adult Name _____ Relation _____

Address: _____ City/State/Zip _____ Phone _____

PRIMARY INSURANCE: Name _____ Effective Date _____ Phone _____

Policy Holder's Name _____ D.O Birth _____

ID# _____ Group # _____

Type of plan: HMO___ POS____ PPO____ EPO____ Indemnity_____ Commercial_____ Other_____

SECONDARY INSURANCE: Name _____ Effective Date _____ Phone _____

Policy Holder's Name _____ D.O Birth _____

ID# _____ Group # _____

Type of plan: HMO___ POS____ PPO____ EPO____ Indemnity_____ Commercial_____ Other_____

Authorization for Release of Information/Receipt of Notice of Privacy Practices/Written Acknowledge form:
I authorize Ideal Gynecology to release to my insurance carrier and its designated agents any medical information, including information related to psychiatric care, drug or alcohol abuse, and HIV/AIDS, necessary to process any healthcare related utilization review or quality assurance activities. I further authorize the release of any medical information to any other providers to whom and from whom I have been referred for healthcare services or who provide consultative services regarding my medical care. This authorization shall remain in effect until revoked by me in writing. I know that I have a right to receive a copy of this authorization upon request and agree that a photocopy of same is as valid as the original.

SIGNATURE OF PATIENT OR GUARDIAN: _____ DATE: _____