OBSTETRICS & GYNECOLOGY ASSOCIATES

OUTPATIENT GENERAL CONSENT FORM

PATIENT'S NAME_____

1. **CONSENT**: I consent to routine medical, nursing care including procedures, examinations, tests, immunizations, regional and local anesthesia, series of treatments/procedures and other treatment by (Dr.)_____ and his/her assistants, associates, or consultants as is necessary in their judgment. I realize that Obstetrics & Gynecology Associates is a teaching facility affiliated with various universities including but not limited to Wayne State University and Michigan State University, and consent to medical care being performed by students, residents, physician extenders or medical support staff who are supervised by experienced doctors and nurses. I know if I have any questions about my care or tests, I should be sure to ask the doctors/nurses/staff about them. I know it is up to me to tell the doctors/nurses/staff about any health problems or allergies I have. I must also tell the doctors/nurses/staff about drugs or medications that I am taking. I consent to the testing and disposal of specimens of my blood, urine, and other bodily fluids, tissues and products. I consent to HIV testing having received verbal explanation and education materials regarding HIV testing; I understand that an HIV (human-immunodeficiency virus) and/or a HBV (hepatitis B virus) or HCV (hepatitis C virus) test may be done upon me without my further consent if a doctor, health professional or employee sustains percutaneous, mucous membrane or open wound exposure to my blood or other bodily fluid.
2. **ADDITIONAL CONSENT FORMS**: I understand that for certain procedures deemed necessary by my physician(s), I will be required to sign a special consent form. Further, if I do not fully understand a procedure or its risks, consequences and alternative methods of treatment, I have the right to question the appropriate health care professionals.
3. **RELEASE OF INFORMATION**: Obstetrics & Gynecology Associates releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practices.
4. **INSURANCE**: I authorize the doctor and the staff to review my insurance coverage with my insurance company. I authorize payment of my insurance benefits to be made directly to the doctor. I agree to pay in full any and all charges not covered by insurance or other benefits. I understand that providers may bill separately.
5. **NO GUARANTEES**: I understand that the practice of medicine is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the doctors or assistants. I understand that no contract, warranty, guarantee, or promise concerning the results of medical service is made. This consent to treatment form is not a contract, nor is it an offer to contract, nor is it an acceptance of an offer to contract.
6. **PERSONAL PROPERTY**: I understand and agree the Obstetrics & Gynecology Associates shall not be liable for the loss or damage of any personal property which may or may not be given to Obstetrics & Gynecology Associates staff during my stay.
7. **NOTICE OF PRIVACY PRACTICE**: I have received a copy of Obstetrics & Gynecology Associates Notice of Privacy Practices. I understand that additional copies of the notice will be provided to me upon my request.

I CERTIFY THAT ANY AND ALL INFORMATION PROVIDED BY ME IN FURTHERANCE OF MY APPLICATION FOR HEALTH CARE BENEFITS ARE TRUE. I HAVE READ THIS FORM. IT HAS BEEN FULLY EXPLAINED TO ME, AND ALL OF MY QUESTIONS ABOUT THE FORM HAVE BEEN ANSWERED. I UNDERSTAND ITS CONSENTS.

_____ __ _____

Patient Signature Date Patient's Personal Representative's Signature Date

_____ _____

Witness Date Representative's Authority To Act/Relationship to Patient