PAVILION WOMEN'S CARE

101 Beckett Lane, Suite 506, Fayetteville, GA 30214

SIGNATURES OF AUTHORIZATION

GUARANTEE OF ACCOUNT

I hereby guarantee the payment of all accounts for services rendered by Pavilion Women's Care. For payment of said accounts for services, I hereby waive all claims of exemption under the State of Georgia and agree to pay, if necessary, all costs of collection, including attorney's fees.

Signature______________________________ Date______________________

ASSIGNMENT OF BENEFITS

I hereby authorize payment of benefits directly to Pavilion Women's Care, otherwise payable to me for professional services rendered, but not to exceed the charges for these services. I understand that I am financially responsible for charges not paid by my insurance company and not covered by this assignment.

Signature______________________________ Date______________________

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Pavilion Women's Care to furnish any medical information requested by insurance companies with whom I have coverage or any public or private agency which may be assisting in payment of my care, for which information is necessary to process insurance claims; furnish information that these same agencies may request from Pavilion Women's Care for quality assurance purposes and utilization reviews.

Signature______________________________ Date______________________

CONSENT TO TREATMENT

I consent to medical treatment by Pavilion Women's Care. I understand the physicians and staff of Pavilion Women's Care will not discuss my health information with others unless I expressly authorize them to do so.

Signature______________________________ Date______________________

CONSENT TO TREATMENT (MINOR)

I consent to the medical treatment of my minor charge in my presence and in my absence by Pavilion Women's Care. I understand the physicians and staff of Pavilion Women's Care will not discuss and are prohibited by Georgia statue from discussing with me, the health information of my minor charge unless expressly authorized by her to do so.

Signature (Parent/Guardian) ____________________ Date______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the Notice of Privacy Practices from Pavilion Women's Care. I understand the content of the notice of Privacy Practices. I understand that I will be provided with a copy upon request.

Signature______________________________ Date______________________

COMMUNICATION AUTHORIZATION

I understand that as part of my health care Pavilion Women's Care may need to contact me to confirm appointments, provide test results, for instructions or to provide or obtain other information. I understand that the minimum necessary information needed will be given when communicating with me indirectly. I authorize Pavilion Women's Care to leave a voice mail communication on my

[ ] cell phone [ ] home phone [ ] work phone.

Signature______________________________ Date______________________

I further authorize Pavilion Women's Care to discuss matters related to my condition/care with the following:

______________________________ ______________________

Name (Please Print) **Relationship**

Signature______________________________ **Date**______________________