CONSENT OF TREATMENT:
I give my permission to The Woman's Clinic, to administer treatment and perform necessary minor operative procedures in diagnosing and or treating my condition. I also give permission to The Woman's Clinic to retrieve my prescription history. By signing this form, I am granting consent to The Woman's Clinic, to use and disclose protected health information for the purposes of treatment, payment and health care operations. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full. (You have the right to request us to restrict how we use and disclose your protected health information. We are not required by law to grant your request, but if we do, we are bound by our agreement. You have the right to revoke this in writing, except to the extent we already have used or disclose your protected health information in reliance of your consent.)

It is further agreed that the undersigned shall pay all costs of collection, including reasonable attorneys' fees, court costs, collection agency fees, expert witness fees, costs of investigation, late charges, and interest on any amount due or declared to be due incurred by [TWC] as a result of non-payment of any balance due to [TWC], including those incurred in post-judgment collection efforts and in any bankruptcy proceeding. The balance due shall bear interest at the lesser of 12% per annum or the maximum rate allowed by law.

Signature:____ Date: ______________________

NOTICE OF ADDITIONAL CHARGES:
If you have a biopsy performed, culture swabbed, or lab work drawn there will be an additional charge billed to you or your insurance company directly from the lab for performing the test.

Signature:____ Date: ______________________

NOTICE OF PRIVACY PRACTICES:
I have received and read how my healthcare information is being used. I will list any additional person or person's to whom I wish to review or share my medical history.

Signature:____ Date: ______________________

Listed below are the additional person or person's I give permission to review or share my medical history with.

Name: ____ Relationship: _________________________

Name: ____ Relationship: _________________________

Name: ____ Relationship: _________________________