University Women's Wellness
Office: 954-644-0149 Fax: 855-592-1225

PATIENT CONTRACT WITH CONSENT TO TREAT

CONSENT TO TREAT

By signing this form, I understand that I am consenting that the healthcare providers at University Women's Wellness can provide and perform medical care, tests, procedures or a medically indicated examination including but not limited to a pelvic exam as agreed upon in the best interest of my health. We will do our best to charge your insurance for your healthcare services; but those services, tests or procedures not covered by your insurance, if applicable, will ultimately be the responsibility of the patient. We encourage you to contact your insurance provider to understand the extent of your healthcare coverage, exclusions and limitations.

_____ **Patient Initials**

CO-PAYMENTS AND EXISTING ACCOUNT BALANCES

Co-payments are due at the time of service. If you have an existing account balance at the time of your visit, you are expected to pay the balance at your visit or set up a plan to make timely payments. See the front desk for more information on available payment options.

_____ **Patient Initials**

APPOINTMENT CANCELLATIONS and LATE ARRIVALS FOR APPOINTMENTS

There will be a $25 charge for ANY appointment not cancelled with a 48-hour notice. We have an appointment reminder system that notifies you via e-mail or text so if you must cancel, please use the system. You are considered late if you arrive more than 15 minutes past your scheduled time. We will do our best to see you, but you may be asked to wait or reschedule.

_____ **Patient Initials**

BY SIGNING THIS CONTRACT, I, AS THE PATIENT, AGREE TO BE AN ACTIVE PARTICIPANT IN MY CARE AND THAT I UNDERSTAND THAT I MAY BE DISCHARGED FROM THE CARE OF UNIVERSITY WOMEN'S WELLNESS AT THE DISCRETION OF THE PHYSICIAN IF ANY OF THE ABOVE TERMS ARE NOT FOLLOWED.

I FULLY UNDERSTAND AND ACCEPT THE TERMS STATED ABOVE:

Patient Name : **Date of Birth :**

Patient Signature: **Date:**