MEMORIAL WOMEN'S SPECIALISTS

929 Gessner, Suite 2130 ● Houston, Texas 77024
Phone: 713-935-9100

WELCOME TO OUR PRACTICE

Consent for Treatment ©2006, ©2013

I voluntarily give my permission to Memorial Women's Specialists and its medical staff, associates, technical assistants, covering physicians, and other associated and consulting healthcare providers to provide medical services. I am authorizing treatment for as long as I receive medical care, or until I withdraw my consent in writing.

Signature of Patient Printed Name Date of Birth Date

Signature of Legal Guardian (if Minor or Legal Guardianship) Date

Printed Name of Legal Guardian Relationship to Minor

Statement of Financial Responsibility/Assignment of Benefits

I acknowledge that I am legally and financially responsible for all charges in connection with the medical care and treatment provided by Memorial Women's Specialists and its medical staff, associates, technical assistants, covering physicians, and other associated healthcare providers. I assign and authorize payments from third party payors, such as insurance carriers, to Memorial Women's Specialists. I am responsible to pay for co-payments, finance charges, fees for any check returned by a bank without payment, and any and all costs incurred in attempting to collect payment and past due balances.

Missed appointments compromise patient care. At least 24 hours notice must be given if you are unable to keep an appointment, or else a fee of $25.00 will be charged to the patient.

I authorize release of necessary medical and financial information to my insurance carrier for the processing and review of claims related to treatment and payment for that treatment. I also authorize payments of such claims to be made directly to Memorial Women's Specialists. Any surgical and/or medical benefits otherwise payable to me are not to exceed the practice's stated charges. I understand that I am financially responsible for charges not covered by my policy. I acknowledge that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or provisions regarding medical necessity, and I am responsible for payment. I also understand that preverification and precertification of benefits do not guarantee payment and coverage of benefits by my insurance carrier. I accept financial responsibility for fees not paid in full, co-payments, policy deductibles and co-insurance except where my liability is limited by contract or State or Federal Law.

Signature of Patient Printed Name Date of Birth Date

Signature of Legal Guardian (if Minor or Legal Guardianship) Date

Printed Name of Legal Guardian Relationship to Patient