Lifespan Physician Group, Inc.

Lifespan Physician Group OB GYN Associates

CONSENT TO EXAMINATION AND TREATMENT PATIENT AGREEMENT

I understand that I may require medications, examinations, diagnostic procedures or other treatments in connection with my condition. I hereby consent to the performance of such examinations, treatments and procedures as such personnel deem necessary or advisable. I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in the outpatient practice. I understand that I have the right to withhold consent to any medical or surgical procedure. I understand that the hospital has the right to decline to permit the performance of any procedure if there is not satisfactory assurance that informed consent was given. I realize that if I withhold consent for a recommended procedure that treatment may be rendered partially or wholly ineffective. I understand that physicians on the staff of this outpatient practice are employees of or are contracted with the hospital.

RESIDENTS AND TRAINEES

I understand that during my treatment I may be examined and treated by personnel in training, and I consent to appropriate care by these trainees under proper supervision.

RIGHT TO ADVANCE DIRECTIVES

I may request written information about my right to make medical decisions and to have advance directives (in the form of a living will or Durable Power of Attorney for Health Care).

Advance Directive: None: _____ Provided: _____ To be provided by: _____ On File:_____

PHOTOGRAPHS, VIDEOTAPES, DIGITAL OR OTHER IMAGES

I understand that photographs, videotapes, digital or other images may be taken to document my medical condition or care, or for the purposes of education of healthcare workers, and for documentation of my identity in my eCW medical record. I understand that cell phone use is prohibited for the purpose of taking or transmitting photographs, video recordings or voice recordings of patients, medical staff, or hospital employees without written authorization.

ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I hereby authorize payment of my health insurance benefits directly to the hospital and to any physician rendering services during this visit. I understand that I am responsible for charges not covered by my insurance company and I understand it is my responsibility to meet the contract requirements of my health plan. Failure to meet contract requirements may result in charges, for which I am financially responsible. I understand I may receive separate bills from persons providing emergency care, anesthesia services, interpretation of x-rays, physicians billing or other services not billed by the hospital. I authorize any physician providing care to release to the insurance company or governmental agency under which I am entitled to medical benefits any and all health care information related to this hospital visit. I also authorize release of this information to my referring and/or primary care physician. I further understand that I may receive separate bills for physician services and outpatient hospital facility services.

MEDICARE AUTHORIZATION

I certify that all information given by me in applying for payment under Medicare Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the hospital or its physicians for any services, including physician services, furnished to me during this visit. I authorize any holder of medical information or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine my entitlement to these Medicare benefits or benefits for related services.

ACKNOWLEDGMENT

I certify that I have read the above and it has been explained to me so that I understand it. I certify that I am the patient or duly authorized by the patient as his/her general agent to review the above and accept its terms.

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF THE LIFESPAN PRIVACY NOTICE

I have received a copy of the privacy notice. It describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time. I may obtain a revised copy by calling any Lifespan Partner at (401) 793-7074 or (401) 444-4728, or by logging on to www.Lifespan.org.

_____ _____ _____

Patient Patient's parent/agent/representative Relationship to Patient

_____ _____

Date Account Number

REV 12/11/12