HIPAA CONSENT TO TREAT

Brent Suozzi, MD

8051 S. Emerson Avenue
Suite 400
Indianapolis, IN 46237

PH: 317.790.3355
FX: 317.790.3002

www.indianaurogyn.com

To establish a doctor-patient relationship we need your permission to treat you.

Our providers at Indiana Urogynecology, during my course of treatment, may perform various tests and procedures, in our office or other facility. Our providers will explain the importance of testing so I can make an informed decision regarding my care. I accept the responsibility to ask questions to insure adequate understanding. After being informed about my care, I authorize these services in accordance with my provider's medical judgment. It is my right to refuse any treatments or procedures.

By signing this consent for treatment, I affirm that I am 18 years of age or older. If under the age of 18, my parent or legal guardian must give consent for treatment; in this case, this person attests they are the legal guardian of the minor who will be receiving the care. This consent-to-treat is valid for the duration of the provider-patient relationship with Indiana Urogynecology or until I, my parent or legal guardian, revoke this consent-to-treat, in writing. A request to modify information is permitted at any time.

Indiana Urogynecology may release my medical information to facilitate payment of services rendered, in accordance with state law. I understand that I am financially responsible for the cost of services provided by Indiana Urogynecology.

If requested, a Notice of Privacy Practices summary will be provided.

RELEASE OF INFORMATION

Patient Name: ____ DOB: ______________

Patient Email: ____ SS#: ______________

Home Phone: ______________ Cell Phone: ____________ Alternate Phone: ___________

Please **initial below** where we have your permission to leave messages concerning appointments, lab or test results, prescription, or billing information.

Appointments, Lab, Test Results, Prescription, or Billing Information:

Home Voicemail_____(initial) Cell Voicemail_____(initial) Text_____(initial) Email_____(initial)

The following people can discuss my medical information with Indiana Urogynecology:

Name: ________________________ Relationship: __________ Phone: ______________

Name: ________________________ Relationship: __________ Phone: ______________

Patient Signature: ______________________________________ **Date:** ______________

Parent/Guardian: ______________________________________ **Date:** ______________

"By supplying my home phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my schedule appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam or any other healthcare related function."