Venus Ob-Gyn

GENERAL CONSENT FOR TREATMENT

I hereby authorize the doctors at VENUS OB-GYN to evaluate, diagnose and treat and otherwise care for, including tests or procedures. This is a general consent for treatment for any services rendered here in the office, i.e. pap smear, breast exam, pelvic. If your plan of treatment requires further procedures, you will be consented on those specific procedures.

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Assignment to Release Information

I hereby authorize direct payment of surgical/medical benefits to VENUS OB-GYN for services rendered by them in person or under their supervision. I understand that I am financially responsible for all of the fees or any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize VENUS OB-GYN to release any medical of incidental information that may be necessary for either medical care of in processing claims or applications for financial benefits.

Medicare

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf to VENUS OB-GYN.

Print Patient Name: ____________________Date of Birth: __________
Print parent/Guardian Name: ____________________

Patient/Legal Guardian Signature ______________________________Date_________

Relationship (if not signed by patient): ______________________________