119 North 51st St. Suite 200 / (402) 932-8020
16909 Lakeside Hills Ct. Suite 201 / (402) 991-1900
Emergencies & After Hours / (402) 932-8020
Medical Record Fax / (402) 905-3041
Office Fax / (402) 905-3042

CONSENTS OF OMAHA OB/GYN ASSOCIATES, P.C.

CONSENT TO TREAT:
I voluntarily consent to medical treatment and diagnostic procedures by Omaha OB/GYN Associates, P.C. I consent to the testing for infectious diseases, such as but not limited to syphilis, hepatitis, HIV/AIDS, and testing for drugs if deemed advisable by my physician.

HIV(Human Immunodeficiency Virus) is the virus that causes AIDS (Acquired ImmunoDeficiency Syndrome). A positive HIV test means that HIV antibodies have been detected, and that the individual has probably been infected with HIV. A negative test means that the antibody to HIV has not been detected, and the individual has probably not been infected with HIV.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations.

CONSENT TO E-PRESCRIBING PBM:
I hereby authorize that Omaha OB/GYN Associates, P.C. can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I was provided with the Notice of Privacy Practice of the Medical Practice named at the top of this page.

AUTHORIZATION FOR RELEASE OR INFORMATION:
I hereby authorize the release of my medical records by Omaha OB/GYN Associates, P.C. to my attending physician, hospitals and third party payer (whether an insurance co., government agency, employer or self insurance employer or utilization review organization).

ASSIGNMENT OF BENEFITS:
I hereby assign to said physician all right, title and interest to any benefit payable for medical coverage. I direct that such benefits be paid directly to said physician and I will be responsible for any charges accrued and not paid by the insurance company. **I understand I am responsible for all co-pays, deductibles, co-insurance and any non-covered services.**

CYNCHEALTH:
Omaha OB-GYN Associates, P.C. participates in the Nebraska Health Information Initiative Inc., dba CynHealth. Cync Health is Nebraska's state-wide, internet-based, health information exchange designed for health care clinicians and health insurers to safely exchange information for treatment and payment purposes. Your health information will included in CyncHealth unless you opt out. You may do so by contacting CyncHealth at 402-506-9900

CONSENT FOR SHARING of PROTECTED HEALTH DATA and INFORMATION:
Please list the names and relationship of family members or other persons, if any, whom we may inform verbally and/or copy of records to about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

1._____ 2._____

Can confidential messages (i.e. appointment reminder, test results, etc.) be on your telephone answering machine or voicemail? *I am fully aware that a cell phone is not a secure and private line.* **YES** _____ **NO** _____

_____
Patient's Name (PRINT)

_____ _____ _____
Signature of Patient or Responsible Party **Responsible Party Relationship to Patient** **Date**

For Practice Use Only: Witness
Signature of Practice Employee _____Date_____
Doctor_____ Acct. #_____