Lifecycle Women's Health
37 Mill Street, suite 13, Brunswick, ME 04011
169 South Road, Readfield, ME 03455
P:207-835-1720 F:949-543-2750

Consent for Treatment

I _____ (patient name) give permission for **Lifecycle Women's Health** to give me medical treatment.

1. I allow **Lifecycle Women's Health** to file for insurance benefits to pay for the care I receive.
   I understand that:
   - **Lifecycle Women's Health** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

2. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

3. I consent to the use of or disclosure of my protected health information by Lifecycle Women's Health
   - for the purpose of providing treatment
   - obtaining payment or conducting health care operations as explained in the Notice of Privacy Practice.
   - I may revoke this consent in writing except if actions rely on this consent.

4. I understand that a chaperone or assistant is not provided by Lifecycle Women's Health during examinations, however I am encouraged and allowed to bring a family member or friend with me to support me during exams if desired.

May we phone, email, or send a text to you to confirm appointments? Yes ☐ No ☐

May we leave a message on your answering machine at home or on your cell phone? Yes ☐ No ☐

May we discuss your medical condition with any member of your family? Yes ☐ No ☐

If YES, please name the members allowed: _____

Patient's Signature_____

_____ _____

Parent or Guardian Signature (for children under 18) Date

_____ _____

Print Name Date