Total Women's Health of Baltimore
General Consent for Treatment and Payment

I, ____, knowing that I am experiencing a condition that requires diagnostics, medical or surgical treatment do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instruction of Dr. Dionne Oliver, or her designee as is necessary to her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination by Dr. Dionne Oliver.

I understand that Dr. Dionne Oliver id accepting me a as patient and that I am responsible for paying for any services I receive that are not covered by my Commercial/Private Insurance, Medicare or Medicaid benefit plan. These could be serviced that my insurance doesn't cover or if my plan has a pre-existing waiting period that has not been met.

____
Patient/Guardian (please print)

____
Patient/Guardian (signature)

____
Office Staff Witness

This consent is for a digital photograph to be taken of you at the time of your visit to place into our electronic medical records. The digital picture is to be used in our medical office for the physician and the staff.

(Please check one)

____ I consent to the picture

___ I do not consent to the picture

___________________________________ ___________________________________
Patient Signature Date

<u>**Total Women's Health of Baltimore**</u>
Dionne D. Oliver, MD, PA

Patient Release of Information

I, ____, hereby authorize Dr. Dionne Oliver and her staff to act on my behalf by releasing information regarding my healthcare to the following individuals:

___________________________________ ___________________________
Name Relationship to patient

___________________________________ ___________________________
Name Relationship to patient

☐ I elect not to release my healthcare information

_________________________________ ___________________________
Patient/Guardian Name Patient Guardian Signature

PLEASE CHECK THE BOX BELOW IF YOU WOULD LIKE US TO USE YOUR BIRTHDAY AND ADDRESS TO VERIFY THE PERSON OBTAINING INFORMATION ABOUT YOU:

☐ Please use my Birthday and address for confirmation

OR: CREATE YOUR OWN QUESTION AND ANSWER BELOW:

Question:

____

Answer:

____

This release is good for 1 year from the date of signature. If this release is to be voided sooner than 1 year, you must make your request in writing.

I, ___________________________________, acknowledge that I was provided a copy of the Notice of Privacy Practices (HIPPA) in the provider's office and that I have had the opportunity to read and understand the notice.

____________________________________ ___________________________
Patient Signature Date