Southcoast Woman's Care

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Patient Name: _____ Date:_____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

INITIAL EACH STATEMENT. SIGN AND DATE AT BOTTOM.

The providers of Southcoast Woman's care will when necessary refer me to another provider, hospital, and or clinic for care. I give permission to Southcoast Woman's Care to send any needed information contained in my medical record to that provider, hospital and or clinic.

Also, I give permission to the provider, hospital and or clinic to which I was referred to send copies of any reports or results to Southcoast Woman's care

Initial_____

I give permission to allow my medical records to be faxed to another provider, hospital or clinic if necessary.

Initial_____

I understand that I am responsible for payments of all services rendered to me that are in the best interest of my medical care. This includes services not covered by medical insurance carrier.

Initial_____

I give permission to Southcoast Woman's Care to leave messages on my home/cell answering machine (if available when I cannot be reached otherwise. Messages my be left for appointment reminders

Initial_____

IMPORTANT NOTE:

We are unable to return your call when you have
CALL INTERCEPT or BLOCKED CALLING. Please remove these blocks
or provide us with an alternate way of returning your call.

Patient Signature:_____ Date:_____

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