We would like to thank you for choosing Fort Sanders Women's Specialists & Perinatal Center for your Health Care Needs

We are committed to providing an office environment that is professional, caring, and respectful of your time and privacy. The following agreement outlines communication information and office policies that are important in providing you with the absolute best care.

DISCLOSURE CONSENT: I can ask for and receive a copy of the Notice of Privacy Practices for this office upon request. I understand that it may/will be necessary to contact me with test results, billing questions, information about referrals to other offices, or to obtain medical information which may be needed to provide me with appropriate care.

How do you wish to be contacted for billing/insurance questions & health related questions we may have for you?:_____
May we leave messages on your voice mail or answering machine?: _____
May we speak with a family member or leave messages for you with another person(s)?
If so, Name & Relationship to You:_____
Phone #:_____
Alternate: Name & Relationship:_____
Phone #:_____

I understand FSWS & FSPNC may need to disclose my protected healthcare and personal information to another entity (pharmacies, making referrals, your insurance company) and I consent to disclosure for these permitted uses, by fax or telephone.

Our Patient and Guest Agreement with you is as follows:
We ask that you not bring any food or drinks into our waiting rooms or exam rooms.
Please eat or drink all food items before entering our suite as other patients may be fasting for a test or have food allergies.

Due to LIMITED SPACE in our office we can only allow 2 people, including children, in back with you during your appointment. If you are having an ultrasound, we allow 2 people to switch out half way through the ultrasound so other family members may be included. We can only allow 2 guests at one time in the ultrasound room due to very limited space.

CELL PHONES: Please- Turn off all cell phones or your ringer while in our office so that our Staff may give you undivided attention – for Privacy reasons, photographs are not to be taken out of respect for the privacy of other patients.

I have read the agreements above and understand I will receive a copy of this notice for my records.

Patient Signature **DATE** **Account Number**

Signature of Guardian if Patient is a Minor