

**Bala Women's Health**

Helene Koch, DO  
Obstetrics & Gynecology

25 Bala Avenue  
Suite 205  
Bala Cynwyd, PA 19004

**Consent for Treatment and Authorization to Pay Benefits:**

*Consent for Treatment:*

I hereby generally consent to the rendering of care, which may include routine diagnostic and therapeutic procedures, as the attending physician and such associate associates and other health care providers deem necessary.

I understand that:

- A) It is customary, except in case of emergency or extraordinary circumstances, that no surgical or invasive procedures are performed upon a patient unless and until she has had an opportunity to discuss them with the physician or other health professional.
- B) Each patient has the right to consent; or to refuse consent, to any procedure without her full knowledge and consent. I understand the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as a result of examination or treatment in this office.

*Authorization to Pay Benefits:*

*Medicare Patients*

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

*Commercial Insurance Patients*

I authorize that any insurance benefits for services and/or medical care rendered by Bala Women's Health, or its designees be released by the insurance carrier or others who are financially liable for services and/or medical care. I authorize Bala Women's Health, or its designee, to release to insurance carriers or others who are financially liable for services all medical records and other information needed to substantiate payment for related services.

*Payment Guarantee*

I and the undersigned agree to assume full financial responsibility, and to personally guarantee payment of all charges hereafter incurred at Bala Women's Health and not paid by the insurance. This payment is expected within 30 days of notification of any balance not paid by the insurance carrier. I understand that if this bill is not paid within this time period, the account may be turned over to the designated collection agency. I understand that I will be expected to know if referrals are necessary.

*I certify that I have read and fully understand the above.*

Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_\_