ROBERT D. PLAMBECK, M.D., P.C.
Obstetrics & Gynecology

**********GENERAL CONSENT FOR **ALL PATIENTS**********

1. **Consent to Treatment:** I, the undersigned, hereby consent to medical treatment. In addition, I give permission to have a biopsy(s), minor surgical procedures and any subsequent treatment as deemed necessary as long as the risks and complications are discussed with me prior to the procedure. I understand that no guarantee has been made as to the results that may be obtained.

2. **Release of Information:** I authorize the release of any or all medical information to my primary care provider or referring physician, and to consultants as needed to provide continuity of care for my medical needs. Additionally, I authorize the release of medical and financial information to my insurance carrier(s) and their business associates if needed and as necessary to process insurance claims, insurance applications, and prescriptions.

3. **Assignment of Insurance Benefits:** I hereby authorize payment of medical benefits to the office of Robert D. Plambeck, M.D., P.C. for services provided. I understand that I am responsible for any health insurance deductibles, co-payments, co-insurance and non-covered or ineligible services.

4. **Acknowledgement:** My signature acknowledges that I have read and understand each of the preceding sections 1 through 3.

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to patient: _____

Witness: _____ Date: _____

**********MEDICARE PATIENTS** PLEASE READ AND SIGN BELOW**********

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement: *I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits be paid directly to the office of Robert D. Plambeck, M.D., P.C. Regulations pertaining to Medicare assignment of benefits apply.*

Signature as it appears on Medicare Card: _____ Date: _____

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file: *I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. Iauthorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits of the benefits payable for related services.*

Signature as it appears on Medigap Card: _____ Date: _____

**********CONSENT FOR TREATMENT OF **A MINOR**********

The age of majority for the State of Nebraska is 19. Treatment for services to anyone under the age of 19 must have the consent of a parent or legal guardian. Please complete this section if the patient being treated is a minor.

Patient's Name: _____ DOB: _____

Legal Guardian: _____ DOB: _____

Relationship to Patient: _____

By my signature below, I verify my consent, as legal consent for Robert D. Plambeck, M.D. and staff, to perform necessary Medical Services for the above listed patient, who is a minor. I also verify that I have given the appropriate and current financial information to this facility, and will take responsibility for payment of any services denied or considered as patient's responsibility.

Signature of Guardian: _____ Date: _____