Patient Name: _____ DOB: _____ Today's Date: _____

A Woman's Place Care Agreement

Reflex Testing:
Pap tests may reveal that a patient is at risk for the HPV virus, which is associated with cervical cancer. If your test reveals this, AWP authorizes the pathologist to automatically order the High Risk Strain HPV test. We recommend HPV testing with a Pap smear (Cotesting) for all patients between the ages of 30 and 65. If both tests are normal, you will only need a Cotest every five years. Tests will be billed to you and your insurance by the pathology provider.

☐ I Accept ☐ I Decline the High-Risk HPV testing. _____ Staff Initials

Gonorrhea & Chlamydia Testing:
AWP recommends routine Gonorrhea and Chlamydia testing for all women age 25 and under and/or women who have had a new partner since last testing. This will be ordered at your annual exam and/or at your request.

☐ I Accept ☐ I Decline Gonorrhea & Chlamydia testing. ☐ N/A _____ Staff Initials

STD Testing:
AWP recommends routine STD testing including HIV, Syphilis, and Hepatitis B & C testing for all women who have had a new partner since last testing. This will be ordered at your annual exam and/or at your request.

☐ I Accept ☐ I Decline STD testing. ☐ N/A _____ Staff Initials

Lab Results:
AWP recommends that you request access to your lab results during the blood draw. In many cases, you are able to request that labs be sent securely to your phone. If you have questions regarding your lab results upon review, please make an appt to discuss with your provider.

Privacy Practices:
I have been offered the opportunity to review, read, and understand the AWP Notice of Privacy Practice.
I hereby consent that my health records may be disclosed to necessary parties for the purposes of my treatment, payment, and health care services.
I understand I may revoke my consent at any time.
Revocation form must be completed and returned to AWP to be enforced and in effect the day it is received by AWP.

Financial Obligations:
I am obligated to understand, agree, and be financially responsible for services rendered to me by AWP providers.
I agree to pay my balance in full upon receipt of AWP Statement letter or phone call requesting such payment.
I understand and agree that balances over 30 days old will incur a service charge of $30.00 and be considered past due. I authorize the release of any information necessary to process my claims and irrevocably assign all benefits for claims to AWP.
I understand and agree that missed appointments will incur a $30.00 charge if not cancelled within 24 hours prior to the scheduled appointment time.

_____ _____
Patient Signature Date