



Women's Health Alliance

Total Care, Total Trust... For Life

www.womenshealthalliance.com

Customary Patient Consent Form

Patient's Name: _____

Acct #: _____

I voluntarily consent and request Dr. _____ or an affiliated associate of Women's Health Alliance, to perform the necessary examination for evaluation and treatment of any problems I may have in respect to my office visit today and in the future. I understand that medicine is not an exact science and no guarantees have been made to me as a cure or an exact end result. Additionally, I understand that if I am diagnosed with Chlamydia, Gonorrhea, HIV (Human Immunodeficiency Virus), PID (Pelvic Inflammatory Disease), or Syphilis, that by law, Women's Health Alliance is required to report that diagnosis to the Texas Department of Health.

Patient or legal guardian's signature

Relationship to patient

Date

_____ a.m. p.m.
Time

Witness