THE MANHATTAN CENTER FOR Gynecology

AUTHORIZATION TO PERFORM TEST(s)
YEARLY CONSENT

## Authorization to Perform Tests

I authorize Dr. Ronald Blatt, Manhattan Center for Gynecology and/or his associates to perform the following test(s).

| | | |
|---|---|---|
| Pap smear/Thin Prep | ☐ Yes | ☐ No |
| GC/Chlamydia | ☐ Yes | ☐ No |
| Vaginal Culture | ☐ Yes | ☐ No |
| Blood Test(s) | ☐ Yes | ☐ No |
| Ultrasound | ☐ Yes | ☐ No |
| Other | ☐ Yes | ☐ No |

I have been informed and I understand that I will be billed separately by the laboratory if I do not have insurance or if my insurance does not cover any of these tests.Therfore, I acknowledge that I am solely responsible for satisfying those fees.

I have been advised to contact this office for test results in 10-12 working days. Please note that all patients must come back into the office for consultation for abnormal labs and HIV test results.

________________________________________ __________

Patient Signature Date

I , certify that I have informed patient of all test(s) indicated above. I have advised the patient for all associated fees for all tests(s) performed according to the scheduled fees available to us on the date of the test(s).

________________________________________ __________

Manhattan Center for Gynecology Representative date

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