
GASTROENTEROLOGY CONSULTANTS, PA

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PATIENT CONSENT FORM

CHARGES FOR SERVICES RENDERED

All charges for office services are due at the time of my visit to GASTROENTEROLOGY CONSULTANTS, P.A. (the 'Practice'). If an insurance claim is filed by the Practice, I request that payment of all benefits be made on my behalf to the Practice.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges for medical services rendered on my behalf, including those not paid or reimbursed by my insurance company. I am aware of the fact that my insurance carrier may deny payment for the services rendered. Therefore, if payment is denied, I agree to be personally liable and fully responsible for such payment.

SHARING/DISCLOSING HEALTH INFORMATION

I authorize the Practice to share, disclose, or otherwise release medical information about me to my insurance company or any other authorized entity involved in my healthcare in accordance with the provisions of HIPAA (i.e., related to treatment, payment, or healthcare operations). I further authorize the Practice to gain access to medical records with information relevant to my treatment from any and all other healthcare providers, including but not limited to hospitals, laboratories, physicians, and others.

TREATMENT

I further authorize and consent to the Practice's physicians and their assistants and other Practice professional staff providing outpatient medical treatment, supplies, services, equipment and other items related to my healthcare to me as determined to be necessary in their professional judgment. I have been informed of the nature and purpose of the treatment, and potential common side effects thereof, as well as alternative treatment modalities, the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period.

EMERGENCY MEDICAL CARE

In the event that a life-threatening emergency occurs while I am in attendance at the Practice in which emergency medical care or treatment is required, I hereby authorize the Practice and its related providers to arrange for the care and treatment necessary to address my emergency medical condition. I further authorize the treating facility or medical personnel to provide emergency medical care and treatment and I agree to be responsible for all medical and related costs associated with such emergency and follow-up medical treatment.

CANCELLATION

I agree that I will provide at least twenty-four (24) hours notice to the Practice when canceling an appointment and understand that a failure to provide such notice may result in a prolonged waiting period and/or a cancellation fee.

Patient Signature

Date