Gastroenterology & Hepatology Consultants

Authorizations/Consents

Financial Agreements and Authorizations for Treatment:

I hereby authorize Gastroenterology & Hepatology Consultants and its physicians and such assistants as a physician my designate to furnish and perform on or the patient stated above ("Patient") such medical care, examinations and treatment as may be ordered by a Gastroenterology Consultant physician in his or her medical judgment and such medical care, examination or treatment as is reasonable incident thereto. I hereby authorize direct payment to Gastroenterology & Hepatology Consultants of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by Gastroenterology & Hepatology Consultants to the Patient. I understand that, to the extent permitted by applicable law, I am and I agree hereby to be, financially responsible to Gastroenterology & Hepatology Consultants for charges not covered by this agreement, and I hereby guarantee payment to Gastroenterology & Hepatology Consultants on demand for all such charges.

Initials: ____

Authorization to Release Information:

I hereby authorize Gastroenterology & Hepatology Consultants to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient's examination and/or treatment to any insurance company, government agencies and their agents, and professional review organizations with which the Patient may have insurance coverage or which may be assisting in payment of the medical care provided by Gastroenterology & Hepatology Consultants to the Patient. I also hereby authorize Gastroenterology & Hepatology Consultants to release any medical information to any licensed physician, health care provider, medical facility, or designated pharmacy to which the patient may be referred, admitted, or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action already has been taken.

I authorize that my medical information, including reminders, can be left on my answering machine at home. ☐ Yes ☐ No

I authorize that my medical information, including reminders, can be left on my voice mail at work. ☐ Yes ☐ No

Initials: ____

Consent to Obtain Medication Summary

I hereby authorize Gastroenterology & Hepatology Consultants and its physicians and such assistants to obtain any medication history summaries from any previous physician's offices, pharmacies, or data basis with such information to better assist in my medical care.

Initials: ____

HIPAA Acknowledgement

I hereby acknowledge that I consent to Gastroenterology & Hepatology Consultants use and disclosure of protected health information according to the Notice of Privacy Practices available to me at the front desk. I also understand that I have the right to revoke this consent at any time by providing a signed written request. However, I am aware that this revocation will not affect any previous disclosures already made in reliance on your prior consent.

Initials: ____

Cancellation and No Show Policy

I hereby acknowledge that I am aware of Gastroenterology & Hepatology Consultants office cancellation and no show policy. I will try to make an honest attempt to cancel or reschedule my office appointment at least 24 hours prior to my scheduled appointment time.

Initials: ____

I acknowledge that I have read and initialed all above consents of Gastroenterology & Hepatology Consultants.

Signature: _____ Please check one: ☐Patient ☐Authorized Representative

Date: _____ ☐Parent or Guardian of Minor