GATEWAY CARDIOLOGY, P.C.

General Consent and Authorization Form

PATIENT INFORMATION:

First Name _____ Last Name _____
Middle _____Suffix (i.e. Jr. Sr) _____ Birthdate _____
Home Phone (_____) _____ Work Phone (_____) _____

Address_____
Street City/State Zip

Patient SS#_____ Male/Female_____
Marital Status_____

Employer Name _____

Referring Physician_____ Phone (_____)_____

EMERGENCY INFORMATION: (In case of EMERGENCY Notify)

Name_____ Relationship _____

Daytime Phone (_____)_____ Home Phone (_____)_____

Address_____
Street City/State Zip

INSURANCE INFORMATION:

Employer Name of Guarantor (Primary Member) _____

Guarantor Name _____
First Name Middle Name Last Name Suffix

Primary Insurance Name _____ Group Number_____

Identification Number_____

Secondary Insurance Name_____ Group Number_____

Identification Number_____

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ADMINISTRATION OF TREATMENT

I hereby consent to the administration of treatment deemed necessary by my physician(s) and other physicians who my attend me, their associates and assistants, healthcare, professionals responsible for my care, Gateway Cardiology, P.C., and any of its affiliates (Hein after referred to as "GCPC"), the GCPC's house of staff, employees and students to provide medical care, tests, procedures (including, but not limited to, intravenous (I.V.) catheter placement), drugs or drug products, services, and supplies considered advisable by Gateway Cardiology, P.C..

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of medical treatments, diagnostic procedures, or examinations, while in GCPC. I am aware that, except in limited situations (such as in a medical emergency), I am required to sign separate consent forms should I need to undergo surgery or other invasive procedures. I understand I have a right to refuse any procedure or medical treatment.

PATIENT HEALTHCARE INFORMATION: A SUMMARY OF YOUR RIGHTS

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means as applicable.

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms of that permission. You have the right to request restrictions as well as revoke certain uses and disclosures of your personal health information.

You also have the right of access in or order to inspect and obtain a copy of your personal health information contained in your designated record set.

How your patient healthcare information is used by this practice is further explained in our **Notice of Privacy Policy**. We will provide you with a copy of the most recent version of this policy at any time upon your request.

CONSENT TO RELEASE PATIENT HEALTHCARE INFORMATION:

I acknowledge that my medical information may include information relative to alcohol abuse, drug abuse, psychological or psychiatric conditions, Human Immunodeficiency Virus (HIV), and/or Acquired Immunodeficiency Syndrome (AIDS). I authorize Gateway Cardiology, P.C., and my treating physician, to release by electronic means or other ways, any medical information concerning my care, including copies of my medical records to the following:

1. Any health professions involved in my care for the purpose of facilitating the continuity of my medical care.
2. Any person or entity responsible for, or any person or entity acting as agent for, the party responsible for payment, including third party payers, self-insurers, worker's compensation carriers, and governmental agencies, payment for the medical services rendered to me at GCPC by employees of GCPC or any person providing services at GCPC or any affiliate.

3. Any federal, state, or other governmental or quasi-governmental agencies or other such parties as required by law for purposes of reporting or for purposes of determining eligibility in governmental sponsored benefit programs.

4. Any person or entity participating in quality studies, utilization review or similar studies of the care rendered by GCPC affiliates and/or their physicians

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5. Any continuing care, residential or long-term care facility or home health agency for the purpose of providing services for my care

6. To person authorized by GCPC in connection with the performance of supervised research in compliance with the rules and procedures of GCPC. I also understand that an authorized researcher may contact me at some future date.

I acknowledge that the above authorization for release of information to the above-mentioned will need to be renewed yearly and is valid to authorize the release of medical and billing information at any time a valid request is received.

A copy of this form shall have the same force and effect as the original.

I acknowledge that I have read this consent request and understand its contents fully.

ASSIGNMENT OF INSURANCE BENEFITS:

In consideration of any and all medical services, care, drugs, supplies, equipment, and facilities furnished by Gateway Cardiology, P.C. (Hein after referred to as "GCPC"), GCPC physicians and GCPC employees, I hereby authorize direct payment to Gateway Cardiology, P.C. and physicians, of all insurance benefits applicable (including Medicare and/or medical benefits), which are not or which shall be come due and payable to me. In addition, I hereby authorized direct payment to GCPC of all insurance benefits applicable to medical and/or surgical services rendered by physicians for whom GCPC is authorized to charge and bill. If my attending physician and/or other physicians associated with him/her or whom he/she may designate accept insurance assignment then I hereby authorize my insurance benefits to be paid directly to those physicians.

FINANCIAL RESPONSIBILITY:

In accordance with the above terms and in consideration of the services rendered to the patient designated herein at my request for this occasion or services, I guarantee and agree to pay GCPC charges for those services rendered, including any deductibles, co-insurance or amounts not paid by insurance plan, Medicare, Medicaid, Health service plan or health maintenance organization. Consequently, I understand that I may receive a separate bill for their services. Members of health maintenance organizations (and preferred provider organizations) are generally required to comply with certain policies and procedures requiring the use of participating providers and compliance with plan requirements for primary referral, emergency admission, pre-certification and utilization review. These are conditions to payment of benefits by the health maintenance organization (and preferred provider organizations).

By signing the finical responsibility statement, the patient and guarantors acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by health maintenance organization (or preferred provider organization) because of a failure to comply with such coverage requirements or for any reason.

A copy of this form shall have the same force and effect as the original.

I acknowledge that I have read this consent request and understand its contents fully.

Signature of Patient: _____ Date: _____

Please sign below if you have received a copy of Gateway Cardiology's Notice of Privacy Practices.

Signature of Patient: _____ Date: _____