CONSENT FOR TREATMENT
COMMUNICATIONS CONSENT
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
AND
AUTHORIZATION FOR RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

1. CONSENT TO TREATMENT

I, the undersigned, acting on my behalf or as the legally authorized representative of _____ _____ (PATIENT) hereby consent to examination, diagnostic testing and treatment by Florida Digestive Health Specialists, LLP, and its employees and agents (together, FDHS). I understand that the physical examination may include a medically appropriate examination of my pelvic area, and/or rectum and I consent to such examination. I acknowledge that no guarantees have been made to me regarding the results of any examination, care or treatment provided by FDHS.

2. RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of my medical information, including protected health information, concerning my treatment to any third-party payor, including but not limited to health plans and insurers, Medicare, Medicaid, TRICARE and CHAMPVA for payment purposes.

Further, I authorize payment of any insurance or other benefits that may be made on my behalf by any party, including any health plan or insurer, Medicare, Medicaid and any other federal or state health care programs, directly to FDHS. I understand that this assignment of benefits does not relieve me of my obligation to pay FDHS for any charges not covered by this assignment or not paid by insurance or health care benefits.

I understand and agree, whether I sign as Agent or Patient, that I am responsible for and guarantee payment of any charges incurred for the services provided to PATIENT by FDHS. I further understand and agree that I will be responsible for payment of any deductible, co-payment or co- insurance amounts, or any charge that is not covered or paid by insurance, health care benefits or third-party payors.

I authorize FDHS to release PATIENT's medical information, including HIV testing and treatment information, to other parties (which may include providers, payors, business associates or other entities) for the purpose of treatment, payment or healthcare operations.

_____
Signature of Patient or Patient's Legal Representative

_____
Name of Patient's Legal Representative and relation to Patient

Date:_____

COMMUNICATIONS CONSENT

_____(initial) I authorize Florida Digestive Health Specialists (FDHS) to leave telephone messages for PATIENT that may contain medical information at the following number(s):

_____

_____(initial) I authorize FDHS to contact PATIENT at the following email address:

_____

_____(initial) I authorize FDHS to share PATIENT medical information with

_____(Name and Relationship)

3. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you are agreeing that you have received a copy of FDHS's Notice of Privacy Practices, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

_____
Signature of Patient or Patient's Legal Representative

_____
Name of Patient's Legal Representative and relation to Patient

Date:_____

_____
For Office Use Only:

I personally delivered the Notice of Privacy Practices to the above-named patient (or authorized representative of the patient). A written acknowledgement of receipt by the patient or representative was not obtained for the following reason(s):

_____

_____ _____
[Signature of Office Staff Member] [Date]

Name: _____