CONSENT FOR TREATMENT AND FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Lafayette General Endoscopy Center, Inc., creates and maintains a health record describing my health history. I understand that Lafayette General Endoscopy Center, Inc. may use this information as:

1. A basis for planning my care and treatment.
2. A means of communication among many health professionals who contribute to my care.
3. A means by which third party payors can verify that services billed were actually provided.
4. A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals, and
5. A means by which licensing, accreditation, and regulatory agencies can verify that appropriate quality services are provided.

I consent to treatment at Lafayette General Endoscopy Center, Inc. under the care of the medical staff, their associates, partners, or designees. I consent to any or all outpatient care, which encompasses the following as ordered by my physician: interview, physical examination, x-ray examination or fluoroscopy, laboratory procedures, diagnostic procedures, conscious sedation, general and/or local anesthesia, and nursing or medical treatment which my physician may deem necessary or advisable.

I consent to the use and disclosure of my personal health information by Lafayette General Endoscopy Center, Inc. for purposes of treatment, payment, and healthcare operations. I authorize Lafayette General Endoscopy Center, Inc. to apply for benefits on my behalf of covered services. I request payment from my insurance company be made directly to Lafayette General Endoscopy Center, Inc.

You may disclose my health information to the following people:

Name	Relationship	Number to reach them if we are unable to reach you

If no one is listed we cannot give out any information to anyone other than you

Please check your preferred method of contact: (check all that apply)

- ❑ Home phone ❑ Voice mail message
- ❑ Work phone ❑ Cell phone
- ❑ Other (please specify): ______________________________

Is there anyone other than yourself that you prefer us to speak to regarding insurance and billing?

❑ Yes ❑ No

If yes, please state name, relationship and phone number:

Name: ______________________ Relation: ______________________ Phone: ____________________

Patient Signature: ______________________________ Witness: ______________________________

Printed Name of Patient: ______________________________ Date: ______________________________

Patient Representative ______________________________ Relationship: ______________________________
(if patient is a minor or unable to sign)

REV 12/11

Chart Number: ________________