CENTER FOR COLON & RECTAL HEALTH, INC.

Langhorne
215-741-4910

Doylestown
215-348-7600

PATIENT CONSENT

Name (Please print) _____

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1. I give my permission to Center for Colon & Rectal Health, Inc. to access my medication history.

_____ Yes _____ No

2. I would like to read or be given a copy of the HIPAA Notice of Privacy Practices for Center for Colon & Rectal Health, Inc.

_____ Yes _____ No

3. I request that payment of authorized Medicare and/or Insurer benefits be made on my behalf to Center for Colon & Rectal Health, Inc. or their associates for services furnished to me by said physicians. I authorize Center for Colon & Rectal Health, Inc. to release to my insurance company any medical information needed to determine the benefits or benefits payable to related services. I understand that if, under Medicare guidelines, a necessary service is determined to be non-covered, I will personally be responsible for payment. I understand I am financially responsible for any amount denied or partially paid by the third payor. I understand that laboratory, pathology, x-ray, or anesthesia services may be provided by outside sources. I agree that payment for these services will be arranged directly by my insurance carrier or myself.

_____ Yes _____ No

4. You may leave messages on my home phone # _____ _____ Yes _____ No

You may leave messages on my cell phone # _____ _____ Yes _____ No

5. The following may receive my Protected Health Information on my behalf:

_____ Yes _____ No Spouse Name/Phone # _____

_____ Yes _____ No Children Name/Phone # _____

_____ Yes _____ No Other Name/Phone # _____

_____ _____

Patient Signature Date