NOTE: ANY CONSENT NOT AUTHORIZED WILL BE INITIALED IN THE BOX PROCEEDING THE TITLE.

☐ **CONSENT FOR MEDICAL TREATMENT**

The undersigned has been informed of the necessity of treatment by the attending physician for the patient whose name appears on the reverse hereof and that the treatment and procedures will be performed by physicians or their employees. Authorization is hereby granted for such treatment and procedures.

The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained if the patient is unable to sign, implied consent for treatment is given.

☐ **CONSENT FOR RELEASE OF INFORMATION**

I, _____, hereby authorize **SPOKANE DIGESTIVE DISEASE CENTER, P.S.** to release to insurance indicated on reverse of page as well as _____ or any third party payor requesting on my behalf information related to treatment including medical, psychological and/or alcohol or drug abuse, AIDS, or other sexually transmitted diseases for the purpose of charges which may be required for adjudication of the claim for health insurance benefits. This consent will expire one (1) year from the date shown below or when payment in full is received. However, I reserve the right to withdraw this authorization at anytime subject to receipt of payment.

I authorize the Department of Social and Health Services to directly inform **SPOKANE DIGESTIVE DISEASE CENTER, P.S.**, of my status as it relate to Medicaid eligibility, should I pursue eligibility for medical coverage through one or more of the state's programs.

Any release of information under this authorization is from records, whose confidentiality is protected by Federal Law. The receiver of the information is prohibited from making any further disclosures of the information except within the specific written consent of the person to whom it pertains.

☐ **CONSENT FOR MEDICARE**

I certify that the information given by me in applying form payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or Medicare Program of its intermediaries, carriers, or to the Professional Review Organization any information needed for this or a related Medical claim including physician services. I request that payment of authorized benefits be made on my behalf.

☐ **CONSENT FOR AGREEMENT TO PAY AND INSURANCE ASSIGNMENT**

NOTICE TO GUARANTOR – READ BEFORE YOU SIGN: You are entitled to a copy of this agreement at the time you sign. You may pay off the unpaid balance at any time.

In consideration of extension of credit, I (we) individually and as a community hereby promise to pay for service rendered or to be rendered to said patient. I (we) ASSIGN INSURANCE BENEFITS directly to **SPOKANE DIGESTIVE DISEASE CENTER, P.S.** Spokane, Washington. Should the account be referred for collection, the undersigned agrees to pay all court costs, reasonable attorney fees and collection expenses.

The patient whose name appears on the reverse hereof has read the above Consent for Medical Treatment, Consent for Release of Information, Consent for Medicare, Agreement to Pay and Insurance Assignment and understands the same. Authorization is hereby granted for the above consents.

☐ **ACKNOWLEDGMENT OF PATIENT RIGHTS AND RESPONSIBILITIES**

Prior to the date of my procedure, I have received verbal and written information, in a language I understand, and have been given the opportunity to ask questions about: Patient Rights and Responsibilities, Advanced Directives, Physician Ownership Disclosure.

_____ _____

Date/Time Patient Signature / Legal Guardian

_____ _____

Witness Date Relationship to Patient

PATHOLOGY AND LABORATORY