Patient's Name: _____ DOB: _____

CONSENT TO TREATMENT

I am presenting myself for examination and treatment at **Andrew M Romanowsky, MD LLC** and I voluntarily consent to the rendering of such care encompassing routine diagnostic procedures and medical treatment, by authorized agents and employees of the practice, and by its medical staff, or their designees, as in their professional judgment be deemed necessary or beneficial. I further authorize electronic access of my pharmaceutical records, if applicable, for treatment purposes. I understand that my records will only be accessed by authorized individuals.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations in the practice.

I understand that information about my health may be disclosed to public health authorities charged with preventing or controlling disease.

Date **Signature of Patient or Responsible Person**** **Relationship**

** By signing above, I acknowledge that **Andrew M Romanowsky, MD LLC** has informed me of their **Notice of Privacy Practices** for the protection and security of my healthcare information. I also acknowledge that upon request, **Andrew M Romanowsky, MD LLC** will provide me with a copy of their **Notice of Privacy Practices**.

FINANCIAL CONSENTS

Release of Information: Assignment of Benefits, Payment Guarantee

AUTHORIZATON TO RELEASE INFORMATION: **Andrew M Romanowsky, MD LLC** is authorized to release to any insurance companies having coverage on me (or to the employer if coverage is under a group insurance plan) any information pertaining to the diagnosis and/or procedures relative to this practice visit(s).
A photocopy of this authorization shall be considered as effective and valid as the original.

ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY: In consideration of services rendered, I hereby forever assign and give to **Andrew M Romanowsky, MD LLC** all rights, title and interest in the benefits payable for services rendered by said practice, provided by my policy (ies) of insurance. This transaction shall be for the recovery on said policy (ies) but shall not be construed to be an obligation of **Andrew M Romanowsky, MD LLC** to pursue any such right of recovery. Provided, however, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier(s). I hereby authorize the insurance company (ies) to pay directly to **Andrew M Romanowsky, MD LLC** all benefits due under said policy (ies) by reason of services rendered therein. I shall pay **Andrew M Romanowsky, MD LLC** for all charges in excess of the sums actually paid pursuant to said policy (ies). A photocopy of this authorization shall be considered as effective and valid as the original.

Date **Signature of Patient or Parent if Minor**

MEDICARE CERTIFICATION
(Medicare Patients Only)

Patient's Certification, Authorization to Release Information and Payment Request: I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize **Andrew M Romanowsky, MD LLC** to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to **Andrew M Romanowsky, MD LLC** or one of its affiliates on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. I further agree that I will furnish evidence along with the Medical Insurance Policy number(s) that said insurance plan payments have been exhausted or unavailable for payment prior to payment submission and anticipation of payment by Medicare. I assign payment for the unpaid charges for certain physician's services. I understand that I am responsible for any health insurance deductibles and coinsurance.

Date **Signature of Patient**

AUTHORIZATION TO RELEASE INFORMATION

I allow **Andrew M Romanowsky, MD LLC** to speak to _____ // _____ regarding my care.
Name Relationship

I allow **Andrew M Romanowsky, MD LLC** to leave a message at my home or cell regarding any appointments and/or normal test results.

Date **Signature of Patient or Parent if Minor**

CONSENT TO HEALTH INFORMATION EXCHANGE

I consent to allow my provider to use Health Information Exchanges (secure computer networks that allow participating health care and insurance providers nationwide to access healthcare information to enhance coordinate of care) to disclose information to other healthcare organizations or providers. I understand that I have a right to request and receive an accounting of disclosures of access to my information through the HIE at any time.

Date **Signature of Patient or Parent if Minor**