LANDMARK DIGESTIVE HEALTH

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Patient Authorization Record

1. **CONSENT TO TREATMENT:** I voluntarily consent to care involving routine diagnostic tests, procedures, and medical treatment as ordered by my physician. I agree that, as part of the medical procedures or tests that may be performed on me, I may be tested for HIV infection, hepatitis, or other blood-borne infectious diseases if a physician orders the test for diagnostic purposes or in the event of exposure to health care personnel. No one has guaranteed the results that may be obtained from my care.

2. **OTHER PRACTIONERS AND HEALTH CARE EDUCATION:** I understand and acknowledge that if my physician orders additional services such as radiology studies or laboratory tests, these may be performed or the results interpreted by health care personnel who are not employees of Landmark Digestive Health, PSC, but who are independent contractors or employees of an independent contractor. I agree that Landmark Digestive Health, PSC is not responsible for and does not assume any liability for the activities of any physician or practioner who is not its employee. As independent contractors, these physicians and other health care providers may bill me separately for their services. I also understand that, from time to time, students in health care occupations, including but not limited to nursing, physical therapy, radiation therapy, and laboratory sciences, may observe and participate in my care in a supervised environment and I agree that, by signing this document, I am consenting to such student observation and participation.

3. **PHOTOGRAPHY:** By signing below, I consent to photographs (including still and video photography) of myself or parts of my body as deemed necessary for inclusion in my medical record for patient identification/safety and treatment.

4. **NOTICE OF PRIVACY PRACTICES:** Landmark Digestive Health, PSC Notice of Privacy Practices states how it may use and disclose medical information. **I acknowledge that I have received the Landmark Digestive Health, PSC Notice of Privacy Practices.**

5. **ASSIGNMENT OF BENEFITS:** By signing below, I agree to direct payment to Landmark Digestive Health, PSC of any third-party benefits otherwise payable to or on my behalf for the care Landmark Digestive Health, PSC provides to me, including emergency services if rendered. Payment to Landmark Digestive Health, PSC by a third-party payor shall discharge the payor of any and all obligations under my policy to the extent of such payment. I agree to pay for all charges that are not covered by any third-party payor to the extent allowed by law. If my bill must be turned over to a collection agency, I agree to pay Landmark Digestive Health, PSC attorney fees and collection expenses. I agree that this statement applies to all current and future claims.

6. **BILLING:** In order to permit Landmark Digestive Health, PSC to bill for the services it has provided me, I agree to furnish or arrange to have furnished to Landmark Digestive Health, PSC any and all information needed to process my insurance claim, and if I have no insurance coverage, a signed agreement to make payment arrangements. I authorize Landmark Digestive Health, PSC to receive from the Social Security Administration and Medicare eligibility information necessary to process my account. I understand that Landmark Digestive Health, PSC may need to receive verification from my insurance company as to the amount of coverage under my policy for services. I further agree to pay Landmark Digestive Health, PSC for any and all services rendered and expenses incurred for my care.

7. **INSURANCE AND EMPLOYERS:** I hereby authorize Landmark Digestive Health, PSC to disclose information about my care to my insurance company for obtaining payment or the services I receive. I acknowledge and agree that if my medical condition appears to be a work-related injury, Landmark Digestive Health, PSC may provide information about my care to my employer or its worker compensation insurance carrier, if applicable, as necessary to collect payment for services rendered.

8. **FOR MEDICARE RECIPIENTS ONLY:** I certify that the information given by me in applying for 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 the Medicare program or its intermediaries or carriers or to the Professional Review Organization any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

9. **TELEPHONE CONTACT:** I authorize Landmark Digestive Health, PSC and all clinical providers who have provided care to me, along with their billing services, collection agencies, attorneys, or other agents, to contact me on my cell phone and/or home phone manually or by auto-dialer.

10. **COPY:** I agree that a copy of this patient authorization record may be used in place of the original copy.

I, _____ (print name), acknowledge that I have read and understood all the information above and I have had the opportunity to ask questions and have them answered to my satisfaction. I agree to all of the conditions for treatment by Landmark Digestive Health, PSC described above. If I am not the patient, I certify that I am authorized by law to agree to these conditions of admission on the patient's behalf.

_____	_____	_____
Date	Signature of Patient/Parent/Guardian/Power of Attorney	Relationship to Patient

_____	_____	_____
Witness	Date	Time