EG Healthcare

eghealthcare.net

209 Steinway Ave.
Staten Island, NY 10314
718-698-6700

Patient Consent Form

Consent for Medical Treatment. I give consent to EG Healthcare, its staff, medical providers and other practitioners (the "Practice") to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial by the Practice for my health and well being.

Authorization of Payment of Insurance Benefits. I authorize payment to the Practice of all monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical care and treatment to cover the costs of care and treatment. I herby authorize the release of any/all medical records about me for the purposes of payment of the service rendered to me.

Signature on File (For Medicare patients). I certify that the information given to me in applying for payment under Medicare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or Center for Medicare and Medicaid Services, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made to me or on my behalf to the Practice for services provided by the Practice.

Financial Agreement. I agree that in consideration for the services rendered to me, to pay all amounts for which I am financially responsible, in accordance with the rates and terms of the Practice. I understand that to the extent permitted by law, where insurance or other third party benefits are insufficient to pay for all of the services rendered, that I will be responsible for the payment of any balances due as determined by the respective provider of services, including deductibles, copayments, coinsurance or other fees required by insurer, HMO or other benefit plan. I understand that if I have not provided the Practice with accurate and current information regarding my insurer, HMO or other benefit plan/third party payor which provides me with health care coverage, I will be personally responsible for the cost of all care rendered by the Practice. I understand that the Practice may require a consumer credit report in connection with the collection of an account. By signing this form I am providing the Practice as well as its collection agency/attorney with a written authorization to obtain a consumer credit report. I agree to pay all bills when presented. Should the account be referred to an attorney for collection, I shall pay all reasonable attorney fees and collection expenses. I understand that there will be a $25.00 charge for all returned checks

Authorization for Release of Information. By signing below, I authorize the Practice to release my health information: (1) to any requesting health care provider for my further diagnosis, care or treatment or for that provider's payment or health care operation purposes; (2) to any person or entity which may be responsible for billing/collection of claims for medical services or products; (3) to any person or entity which is, or may be liable to the Practice or me for all or part of the Practice' charges, including but not limited to, insurance

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companies, HMO or third party payors; (4) to any governments agency or other organization responsible for oversight of the Practice or a third party payor; (5) for the Practice' normal health care operations. I authorize the Practice to communicate with me through test or email, even if not encrypted, and to allow the individuals listed above to access such information through any medium including over the Internet, even though the emails may not be encrypted, and through the Practice's electronic medical record system

Authorization to Access Information: I give consent for EG Healthcare to access all of my electronic Information through Healthix to provide health care.

If I want to deny consent for all provider organizations participating in Healthix to access my electronic health information through Healthix, I may do so by visiting www.healthix.org or by calling Healthix 877-695-4749.

I understand that the Practice may access information from any pharmacy from which I have filled prescriptions. This includes prescriptions for medicines to treat AIDS/HIV, mental health illness, substance abuse, and STDs, if applicable. I further understand that this information will become a permanent part of my medical record. I understand that if I do not wish the Practice to access such information, I must submit such request in writing.

Filming. I understand that photographs or other images of me may be recorded for the Practice's treatment and quality assurance purposes. To the extent that such images identify me, I understand that they shall receive the same confidentiality protections as my other health information.

Acknowledgement of Notice of Privacy Practices. I have received a copy of the Practice' Notice of Privacy Practices, and have had the opportunity to receive assistance in the understanding and exercising these rights.

Signature. I have carefully read and fully understand this informed consent form and have had all my questions answered.

Signature of Patient   Print Name   Date

Signature of Patient/legal Representative   Relationship to Patient