Practice: ICA
2643688

ACCOUNT #

SAUNDERS,KEVIN E
Baker,Donald James MD.
43391507 ED 46
05/01/56 0597460

CAYUGA MEDICAL CENTER AT ITHACA AI
ARROWHEAD EMERGENCY PHYSICIAI
(EMERGENCY DEPARTMENT)
PATIENT SIGNATURE ON FILE FORM

Advanced Directives Provided to: KEJ (Initials) — On File: Yes: ✓ No: ___ — Patient's Rights Reviewed By: KEJ (Initials) — Organ Donor: Yes: ___ No: ✓

GENERAL

CONSENT AND TREATMENT - I have come of my own volition, seeking urgent/emergency treatment. I hereby give my permission to the physicians and professional staff of Cayuga Medical Center to give a treatment or perform test(s) or diagnostic procedures (including x-rays) which may be ordered by a medical center physician(s), his/her assistant; or designees as are necessary in their judgment. I am aware the practice of medicine is not an exact science, and I acknowledge that no guarantees will be made to me as to the results of treatments or examinations in Cayuga Medical Center. I voluntarily consent to emergent treatment and subsequent care, including admission, if deemed necessary by a medical center physician.

Initials KEJ

RELEASE OF INFORMATION - Cayuga Medical Center at Ithaca and/or Arrowhead Emergency Physicians may disclose any or all parts of the clinical record to my (our) insurance company(s) or employer(s) for purposes of satisfying charges billed by Cayuga Medical Center at Ithaca and/or Arrowhead Emergency Physicians. I further understand that it may be necessary to contact my (our) past or present employer(s) in regards to this claim. This authorization does not cover 3rd party liability claims.

I authorize Cayuga Medical Center physician(s) to direct that copies of relevant portions of my medical record be forwarded to such medical practitioners or facilities as may be responsible for my subsequent care.

I authorize Cayuga Medical Center representatives to review my record for quality assurance and/or utilization review procedures. I also hereby authorize and direct Cayuga Medical Center, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my stay at the Medical Center and medical care, and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

I authorize the release of my social security number to manufacturers for the purpose of tracking medical devices.

Initials KEJ

GUARANTEE OF ACCOUNT -Cayuga Medical Center at Ithaca and/or Arrowhead Emergency Physicians. For and in consideration of services rendered by Cayuga Medical Center at Ithaca and/or Arrowhead Emergency Physicians to the below named patient, the undersigned (jointly and severally if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills.

I agree that in consideration of the services rendered I hereby obligate myself to pay the account of the medical center in accordance with the rate and the terms of the medical center. Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fees and collection expense.

I understand that I will receive separate bills for services rendered by specialists such as radiologists, anesthesiologists, private physicians, emergency physicians, and other specialists my attending physician consulted with.

Initials KEJ

MEDICARE

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Cayuga Medical Center at Ithaca and/or my treating provider for any services furnished to me by that physician/provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Initials KEJ

MEDIGAP

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Cayuga Medical Center at Ithaca and/or Arrowhead Emergency Physicians for any services furnished to me by that physician or organization. I authorize any holder of medical information about me to release to my Insurance Company any information needed to determine these benefits or the benefits payable for related services.

Initials ___

OTHER THIRD-PARTY PAYORS

ASSIGNMENT OF INSURANCE BENEFITS - I hereby authorize payment directly to Cayuga Medical Center at Ithaca and/or Arrowhead Emergency Physicians for medical insurance benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physicians or organization furnishing the services performed during this period of hospitalization. In making this assignment, I understand and agree that I am financially responsible to the above party and/or parties for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

Initials KEJ

PATIENT SIGNATURE

This form has been fully explained to me and I certify that I understand its contents. This consent does not constitute a waiver of the right to informed consent to specific procedures or treatment where it is feasible for me or my health care proxy to give, withhold, or revoke consent. I certify that I have read the foregoing and am the patient or am duly authorized by the patient as patient's general agent to execute the above and accept its terms.
THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS. Initials KES

Kevin Ine Saunders / ___
Patient Signature — Insurance Identification Number

___ / 4-4-03 / ___
Patient's Agent Representative and Guarantor Signature — Date — Witness

ICA\SIG2.FRM 8/00

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2643688

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CAYUGA MEDICAL CENTER AT ITHACA A
ARROWHEAD EMERGENCY PHYSICI
(EMERGENCY DEPARTMENT)
PATIENT SIGNATURE ON FILE FORM

Advanced Directives Provided to: TLT **(Initials)** **On File: Yes:** ✓ **No:** ___ **Patient's Rights Reviewed By:** TLT **(Initials)** **Organ Donor: Yes:** ___ **No:** ✓

GENERAL

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Initials TLT

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Initials _____

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Initials _____

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THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS. Initials TLT

X _____ / _____

Patient Signature / Insurance Identification Number

_____ / 4-4-03 / _____

Patient's Agent Representative and Guarantor Signature / Date / Witness

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