Fasting ___ Yes __ No Diabetic __Yes __ No

Cayuga
Medical Center
at Ithaca
101 Dates Drive • Ithaca, New York 14850
(607) 274-4011

56186752

SAUNDERS,KEVIN E
Breiman MD,Robert
X
DOB 05/01/56

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0597460

GENERAL CONSENT AND FINANCIAL AGREEMENT

Advanced Directives Provided:	XKES (initials)	On File: ☒ Yes ☐ No	Patient's Rights Provided:	XKES (Initials)	Organ Donor: ☐ Yes ☒ No KES

GENERAL CONSENT AND TREATMENT
I hereby give my permission to the physicians and professional staff of Cayuga Medical Center to give any treatment or perform any test(s) or diagnostic procedures which may be ordered by my physician, a medical center physician(s), his/her assistant or designees as is necessary in their judgement.

I am aware that 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 the Medical Center. I voluntarily consent to treatment and subsequent care, including admission, if deemed necessary by my physician or a Medical Center physician.

RELEASE OF INFORMATION
I authorize my physician, or a Medical Center physician, to direct portions of my medical record to such medical practitioners or facilities as may be responsible for my subsequent care.

I authorize the 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.

FINANCIAL AGREEMENT
I agree that in consideration of the services rendered, I hereby obligate myself to pay the account 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 who are not employed by the Medical Center such as: radiologists, anesthesiologists, pathologists, private physicians, emergency physicians, and other specialists with whom my attending physician consults. I understand that such physicians may or may not accept my insurance carrier's reimbursement as payment in full.

MEDICARE
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

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 physicians for any services furnished to me by that physician or organization.

ASSIGNMENTS/COORDINATION OF BENEFITS
I hereby assign payment directly to Cayuga Medical Center and physician(s) accepting this assignment of all medical benefits applicable and others payable to me. I understand that I am financially responsible to the Medical Center and physician(s) for charges **not covered** by this assignment or for any and all charges which the insurance carrier declines to pay in accordance with NYS Law and/or my insurance policy. It is further agreed that any credit balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said Medical Center and physician(s) by the insured or his/her family.

This form has been fully explained to me and I certify that I understand its contents.

I certify that I have read the foregoing and am the patient or duly authorized by the patient as the patient's agent to execute the above and accept its terms.

X [signature] 08/06/08
SIGNATURE DATE

[signature]
WITNESS RELATIONSHIP TO PATIENT

03019(Rev. 10/7/03)

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