Fasting ___ Yes __ No Diabetic __Yes __ No

60601572

Cayuga Medical Center at Ithaca

101 Dates Drive • Ithaca, New York 14850

(607) 274-4011

SAUNDERS,KEVIN E
Darling MD,James L.
UC
DOB **05/01/56**

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General Consent and Financial Agreement

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

General Consent and Treatment

I hereby give permission to Cayuga Medical Center and to the physicians and professionals at the Medical Center to provide treatment and perform tests or diagnostic procedures necessary for my medical condition. I understand that most members of the medical staff and adjunct medical staff are independent practitioners who are not employed by or under the control of the Medical Center.

Release of Information

I authorize the Medical Center to direct portions of my medical record to such medical practitioners or facilities as may be responsible for my subsequent care. In addition, I authorize and direct the Medical Center to release to governmental agencies, insurance carriers, or others who are financially responsible for my medical care and to permit representatives thereof to examine and make copies of all records relating to such care.

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 professionals who are not employed by the Medical Center such as: radiologists, anesthesiologists, pathologists, private physicians, emergency physicians, and other specialists who provide care to me. I understand that such professionals 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 the Medical Center at and/or physicians for any services furnished to me by that physician or organization.

Assignment/Coordination of Benefits

I hereby assign payment directly to the 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.

I certify that I have read the foregoing consent, have had any questions explained to me in full and understand its contents. I further certify that I am the patient or duly authorized agent to execute the above and accept its terms.

SIGNATURE

5/12/8 1520
DATE TIME

RELATIONSHIP TO PATIENT

WITNESS

05/09/10

03019(Rev. 10/27/08)

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