

101 Dates Drive Ithaca, NY 14850 (607) 274-4011

General Consent and Financial Agreement

Fasting	Yes	No	Diabetic	Yes	No
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A00088518428

BLAYK, BONZE ANNE ROSE

62

DOB 05/01/1956

Advanced Directives On File Provided: (initials)	Yes No	Patient's Rights Provided:	(initials)	Organ Donor: Yes No
General Consent and Treatment I hereby give permission to Cayuga Meat the Medical Center to provide treatment				
necessary for my medical condition. adjunct medical staff are independent control of the Medical Center.	I und	lerstand that most me	embers of t	he medical staff and
Release of Information				
I authorize the Medical Center to di	rect	portions of my media	cal record	to such medical
practitioners or facilities as may be authorize and direct the Medical Centerriers, or others who are financial	e res ter t lly r	ponsible for my subsolvers or release to governor esponsible for my me	sequent car mental agen edical care	e. In addition, I cies, insurance and to permit
representatives thereof to examine an	nd ma	ke copies of all red	cords relat	ing to such care.
Financial Agreement				
I agree that in consideration of the				
account of the Medical Center. Should				orney for collection,
I shall pay reasonable attorney's fee				
I understand that I will receive sepa				
are not employed by the Medical Cente				
pathologists, private physicians, eme				
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carrier's reimbursement as payment in	.i iui			
<pre>Medicare I certify the information given by me</pre>	o in	annising for narmont	- under Tit	le VVIII of the
Social Security Act is correct.	5 111	applying for payment	t under lit	ie Aviii oi the
Medigap				
I request that payment of authorized	Modi	gan bonofits be made	oither to	me or on my behalf
to the Medical Center and/or physicia				
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that physician or organization.				
Assignment/Coordination of Benefits	the N	indian Conton and al		aggenting this
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assignment of all medical benefits a	ppiic	Madical Conters pays	abre to me.	\ for charges
that I am financially responsible to	the	medical center and p	inysician(s	y for charges
not covered by this assignment or for	r any	and all charges who	ich the ins	drance carrier
declines to pay in accordance with N	YS La	w and/or my insurance	de policy.	
Cell Phone Number	n + c	with my goll whom	number T a	aree that Carria
If I have provided Cayuga Medical Cer	ncer	with my cell phone i	that number	r uging an automated
Medical Center, its agents and contratelephone dialing system or prerecord	ded c	or artificial voice	to discuss	my account, including

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.

current and possible future services, customer service, billing and collections.

I understand that providing my cell phone number is not required to purchase or receive services from Cayuga Medical Center and that I may revoke this permission at any time.

RELATIONSHIP TO PATIENT

DATE

(03019)

TIME



A Member of Cayuga Health System

101 Dates Drive Ithaca, NY 14850 (607) 274-4011

General Consent and Financial Agreement

No Diabetic

BLAYK, BONZE ANNE ROSE

Frederick R Caballes MD

DOB 05/01/1956 62

Advanced Directives Provided: init		Yes No	Patient's Provided		(initials)	Organ Donor:	_	Yes No
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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 not employed by the Medical Center such as: radiologists, anesthesiologists,

hologists, 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 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 and/or physicians for any services furnished to me by that 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.

Cell Phone Number

If I have provided Cayuga Medical Center with my cell phone number, I agree that Cayuga Medical Center, its agents and contractors may contact me on that number using an automated telephone dialing system or prerecorded or artificial voice to discuss my account, including current and possible future services, customer service, billing and collections. I understand that providing my cell phone number is not required to purchase or receive services from Cayuga Medical Center and that I may revoke this permission at any time.

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





No Diabetic Yes Yes

03019)

BLAYK, BONZE ANNE ROSE

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101 Dates Drive Ithaca, NY 14850 (607)274-4011

General Consent and Financial Agreement

Fasting	Yes	No	Diabetic	Yes	No

A00088518428 BLAYK, BONZE ANNE ROSE

F 62

DOB 05/01/1956

(03019)

Advanced Directives On File Yes Provided: (initials) No	Patient's Rights Provided:	(initials)		es No			
General Consent and Treatment I hereby give permission to Cayuga Medical at the Medical Center to provide treatment necessary for my medical condition. I under adjunct medical staff are independent pract control of the Medical Center. Release of Information	and perform tests stand that most me	or diagnos embers of t	tic procedures he medical staff and	d			
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I request that payment of authorized Mediga to the Medical Center and/or physicians for 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.							
Cell Phone Number If I have provided Cayuga Medical Center wi Medical Center, its agents and contractors telephone dialing system or prerecorded or current and possible future services, custo I understand that providing my cell phone m services from Cayuga Medical Center and that	may contact me on artificial voice omer service, bill number is not requi	that numbe to discuss ing and col ired to pur	r using an automated my account, includir lections. chase or receive	d ng			
I certify that I have read the foregoing confull and understand its contents. I further agent to execute the above and accept its to signature RELATIONSHIP TO PATIENT	c certify that I am	ny question the patie	s explained to me in nt or duly authorized OHB TIME LLLLLAMP R	n ed			