Fasting ___ Yes ___ No Diabetic ___ Yes ___ No

A00135688513

A Member of Cayuga Health System

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

A00135688513
Blayk,Bonzeanne R
Adam Law
F 66 DOB 05/01/1956

General Consent and Financial Agreement

Advance Directives Provided:	On File (Initials) BARB	Yes / No	Patient's Rights Provided:	(Initials)	Organ Donor: BARB	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 any 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 physician or organization.

Assignment/Coordination of Benefits

I hereby assign payment directly to the Medical Center and the 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.

Bonze Blayk — 9/21/22

SIGNATURE — **DATE** — **TIME**

Self — BARB

RELATIONSHIP TO PATIENT — **WITNESS** — (03019)