OG

4403 Harrison Blvd. #2855
Ogden, UT 84403

OGDEN GASTROENTEROLOGY

Chad M. Gonzales, M.D.,P.C.

Consent and Conditions of Treatment

As either the Patient or the legally authorized representative of the Patient, the following consents, understandings, and agreement are made on my own behalf or on the behalf of the Patient in partial consideration of the health care services to be provided to the Patient in Ogden Gastroenterology/Chad M. Gonzales MD's facility ("Facility"):

1. **Consent for Services.** On behalf of the Patient, consent is hereby given to the Facility, its independent contractors (see 2.b, below), medical staff, and employees to provide health care services to the Patient, to administer physician orders for the benefit of the Patient, and to provide all related care and services to Patient while in the Facility, including but not limited to all routine and non-routine tests and studies ordered in the belief that they are medically necessary or appropriate for the Patient. See also, 2.a, below. It is understood that Facility services, medical care, and surgery are not exact sciences and that there is a risk of substantial and serious harm involved in such treatments and services, and such risk is accepted in the hope of obtaining beneficial results from such services. It is understood that the Patient and his/her legally authorized representatives have the right to ask questions and to receive answers to such questions about the Patient's condition and the health care services. At this time, all such questions, if any, have been satisfactorily answered. No promises of any particular outcome or successful result have been made, it being understood and accepted that there is some uncertainty involved in health care services for which consent is given.

2. **Miscellaneous agreements and understandings:**
   a. **Medical Education.** Permission is given for persons involved in medical education to be present and/or participate when the Patient receives health care services. Student will be directly supervised by the Physician or staff employees from whom they are receiving training or education.
   b. **Independent Contractors.** It is understood that many physicians and other health care providers furnishing services to the Patient, including residents and interns, are independent contractors or medical students and are not Facility agents or employees. It is agreed that the Facility is not responsible or liable for the actions or interactions of persons who are not Facility employees.
   c. **Personal Property.** It is understood that the Facility is not responsible for personal property.
   d. **Release of Information.** The law requires the Facility to make and keep records of the Patient's medical treatment. The Facility safeguards those records and it uses and discloses such records and the information they contain only in accordance with State and Federal privacy laws. Such uses and disclosures are described in detail in the Facility's Notice of Privacy Practices, which are amended from time to time.
   e. **Assignment of Benefits.** Any and all benefits from insurance companies and other third party payers that are payable to the Patient or on behalf of the Patient for health care services, and all related payments for services rendered or provided to the Patient in the Facility are hereby transferred and assigned to the Facility for the exclusive purpose of obtaining payment for charges associated with health care services provided to the Patient in the Facility. It is understood and agreed that all insurance companies and other third party payers will pay benefits directly to Facility in payment of Facility's charges.
   f. **Financial Responsibility.** Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all health care services rendered to the Patient in the Facility including, but not limited to any amounts not paid by any insurance company or other third party payer. It is understood that the Patient and the undersigned are also responsible to pay all applicable co-payments, deductibles, co-insurance and all charges for non-covered services. It is understood and agreed that charges not paid in a timely fashion will be placed for collection with a collection agency or attorney. At that point the Patient and the undersigned each jointly and severally agree to pay costs and reasonable attorney's fee in connection with the collection process, up to a 40% collection expense incurred by the Facility in attempting to collect such amounts in addition to the attorney's fees and costs will be assessed. A $20 service charge will be assessed for any retuned check or other tender not payable.

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g. **Patient's Certification for Government Health Care Programs.** I certify that the information given in applying for payment for Medicare, Medicaid, Champus, Tricare, or any other government program for payment under Titles XVIII and XIX of Social Security Act or otherwise, is correct. I authorize any holder of medical or other information about me to release to the Tricare administrator, Social Security Adminstration or its intermediaries, or other carriers or program administrators, or to the State or any other payer, any information needed to substantiate and process a claim for payment for this or any related service. I request that payment of authorized charges be made in my behalf directly to the Facility for its charges and for any charges of physicians or other providers for whom the Facility is authorized to bill in connection with its services.

h. **Consent for photographs.** It is understood that in the interest of preserving accurate identification, it may be necessary to obtain facial and/or profile photographs. Such photographs will become part of the Patient's medical record. These photographs will safeguarded as described in 2.d, above.

i. **Communication and contact.** You authorize us to call you at any number you provide or at any number at which we reasonably believe we can contact you, including calls to home, mobile, cellular, or similar devices and other places you may reside or work for any lawful purpose, including and not limited to the emergency contact information provided by you.

The undersigned signs this document either as the Patient or as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding of what I am agreeing to by signing below. I understand that I am entitled to request and obtain a copy of this document.

Beginning April 14, 2003, the following provision applies: I hereby acknowledge that I have received or been offered a copy of the Facilities Notice of Privacy Practices.

_____ _____

Patient's Name (printed) **Date signed**

X_____ _____

Patient's signature or Representative's signature **Representative's Name & relationship to patient**

Staff Member witness: X_____ **Chart/Acct #**_____