

## PATIENT CONSENT FORM

### CONSENT TO MEDICAL SERVICES

I consent to and authorize such medical care which may include a complete examination, lab work, special testing (including x-rays) and surgeries. This consent includes the testing for blood-borne infectious diseases, including but not limited to Hepatitis and HIV (Human Immune Deficiency), a physician orders such tests for diagnostic purposes. I also understand that all my medical treatment is discussed with Dr. Sham L. Gupta.

### ASSIGNMENT OF BENEFITS

This assignment of benefits allows Dr. Sham L. Gupta to be paid directly by my health insurance carrier. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature in all insurance submissions. The above-named doctor may use my health care information and may disclose such information to my Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

### MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits, be made either to me or on my behalf to Dr. Sham L. Gupta for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services.

### RELEASE OF INFORMATION

I authorize Dr. Sham L. Gupta involved in my care to release information and supporting documentation obtained during my visit to any organization, which is or may be liable or responsible for payment of charge associated with my visit.

### NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given Dr. Sham L. Gupta Notice of Privacy Practice. I understand that this notice provides me with information on my privacy rights and how my health information may be used and/or disclosed.

X \_\_\_\_\_  
Patient/Parent/Guardian Date

X \_\_\_\_\_  
Witness Date