MRN #____________________ **DOB_________**

Patient Name________________________

Signature on File

I understand and agree that I and the Responsible Person signing below are responsible for payment of my bills. I authorize the Group to submit claims to my health insurance plans, whether private or governmental, for all services rendered by the Group or by other health care providers involved in my care, including providers not employed by the Group who are referred or consulted for my care by the Group. I assign the benefits of such insurance to the Group and authorize payment of claims directly to the Group.

I consent to the use or disclosure by the Group of my protected health information and any other information about me in the Group's possession for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of the Group. This includes disclosure of information to other health care providers referred or consulted for my care, to health insurance plans, and to others engaged in health care operations such as training, credentialing, quality improvement, legal compliance, contracting, and administration.

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. Protected health information relates to my past, present, or future physical or mental condition and identifies me, or there is a reasonable basis to believe the information may identify me. Protected health information may include information concerning HIV testing, diagnosis or treatment of AIDS, AIDS related conditions, drug or alcohol abuse or related conditions, and psychiatric and psychological conditions (but excluding psychotherapy notes).

I understand the information contained in this form or otherwise given by me to the Group will be used in submitting claims for payment and I certify that such information is correct. I authorize a copy of this form to be used in place of the original, and the use of "signature on file" on all claims submissions. I understand that I am responsible for notifying the Group of any pre-certifications or referrals required by my health plans.

I understand that Group, as used in this Patient Consent Form, means General and Vascular Surgeons of Butler County, Inc.

Patient Signature____ Date_________