GASTROENTEROLOGY & NUTRITION CLINICS, P. C.

Stomach, Colon, Liver & Nutritional Health

3040 Highlands Pkwy. Suite C Smyrna, Georgia 30082
Phone: (404) 681-0000/Fax: (678) 866-2538
E-mail: doc@mypreventivehealth.com

Edward A. Layne, M.D., Director

CONSENT TO TREATMENT AND OTHER ACKNOWLEDGMENTS

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the Performance of any treatments, examinations, medications medical services or diagnostic procedures as ordered or approved by my attending physician(s), Dr. Edward Layne.

1. AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS: I hereby expressly authorize Gastroenterology and Nutrition Clinics and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to Gastroenterology and Nutrition Clinics and all professionals (including independent contractors) providing for such care, and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to Gastroenterology and Nutrition Clinics and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.

2. PAYMENT FOR SERVICES: In return for services to be provided by Gastroenterology and Nutrition Clinics I promise to pay for services rendered by Gastroenterology and Nutrition Clinics to me or for my benefit. If the services I receive from Gastroenterology and Nutrition Clinics are covered by a third party payor, Gastroenterology and Nutrition Clinics may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third party payor determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.

3.. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits).
A copy of this document may be utilized the same as the original.

_____ Date: _____
Patient/Parent/Guardian/Authorized Representative

_____ _____
Print Patient Name Witness

If not signed by the patient, please indicate relationship to the patient on the line below:

_____