Patient Consent Form, Authorization for the Use and Disclosure of Protected Health Information and Financial Responsibility Agreement

I, the undersigned, hereby consent to the administration and performance of all treatments, procedures as may be deemed necessary or advisable in my treatment, and diagnostic procedures or tests. I understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

Privacy: I acknowledge that Gilbert Medical Group Inc. will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. I acknowledge that I have read the notice of Privacy Practices and if I have questions or complaints that I should contact the office manager for Gilbert Medical Group.

Insurance: I assign to Gilbert Medical Group Inc. reimbursement benefits on all insurance policies otherwise payable to me. I authorize Gilbert Medical Group Inc. to submit insurance claims to insurance companies or plan administrators and to apply insurance proceeds to Gilbert Medical Group Inc. I assign all rights, as the insured, to Gilbert Medical Group Inc. to bring an action against my insurance company for benefits due under the insurance policies.

Financial Responsibility: I understand that I am financially responsible to Gilbert Medical Group Inc. for charges not covered by my insurance company. I authorize Gilbert Medical Group Inc. to endorse any checks or other payment instruments to the undersigned and to apply the same to any account of the undersigned or any account for which the undersigned could be liable. I authorize Gilbert Medical Group Inc. to prepare and submit to my insurance carrier or plan administrator all the insurance claims, forms, questionnaires and all other statements or documents required by the insurance carrier or plan administrator. I understand that I am responsible for any health insurance deductibles copayments and coinsurance at the time of services rendered. I also agree that all charges for services rendered that are not covered by any Insurance program, sponsorship, or other third party coverage, are due and payable at the time of service. I hereby acknowledge that if Gilbert Medical Group Inc. has agreed to bill my insurance carrier or other third party payer, it has agreed to do so as a courtesy only. I acknowledge that I may be billed for all services rendered and that if I am more than thirty days delinquent in the payment of any bill, interest on the amount due may accrue at the maximum rate allowed by law. If the account is referred for collection, I agree to pay the attorney's fees, court costs and collection fees associated with the collection process.

Authorization for Release of Prescription Records: I hereby authorize the release of all my prior external prescription medication and prescription equipment or device activity information to Gilbert Medical Group.

Signature: I agree that my electronic signature, which includes, but is not limited to, scanned, photocopied or in a facsimile, will be considered as original and is a means to ensure identity and integrity of the electronic document and/or its reproduction. A photocopy of this consent and agreement shall be considered as valid as the original.

I understand that I am entitled to receive a copy of this authorization and that I may revoke this authorization in writing at any time except to the extent that Gilbert Medical Group has already relied on this authorization, by sending a written notice stating my intent to revoke this authorization to: Gilbert Medical Group. 3868 Sheridan Street, Suite A, Hollywood, Florida 33021.

Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Gilbert Medical Group Inc. I authorize Gilbert Medical Group to bill Medicare for the care of my chronic conditions. Gilbert Medical Group takes part in a program to oversee your chronic conditions and improve your overall wellness. These conditions must be managed effectively in partnership between the healthcare team and patient to maintain the best possible overall health and wellness. The benefits of Chronic Care Management Services are to coordinate visits with your specialists and other facilities and assist with management of medications, review of labs and imaging studies. Medicare will allow us to bill for these services during any month that we have provided non-face-to-face chronic care management services.

Patient or Authorized Representative:

Name:____________________________ Signature:______________________ Date: _________