Iberia Gastroenterology Associates, Inc.

2309 East Main Street, Suite 101
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Phone: (337) 364-3301

Consent for Treatment

The undersigned, as patient or authorized agent of the patient, hereby authorizes and consents to any and all medical and diagnostic treatments as may be deemed advisable by the Healthcare Provider. Being fully aware of the contents of this consent form, the patient voluntarily and knowingly gives their consent for this treatment.

Release of Information

Iberia Gastroenterology Associates, Inc. may obtain from any source and examine, discuss, and disclose the patient's medical record, including medical history, prescription history, examinations, diagnoses, and treatments to treating doctors, Iberia Gastroenterology Associates, Inc. personnel and agents, other healthcare providers involved in the patient's care, medical researchers, audit committees, care evaluators, and state and federal agencies for the purposes of treatment, payment, or healthcare operations. For further details about these uses and disclosures see the organization's Notice of Privacy Practices. Iberia Gastroenterology Associates, Inc. reserves the right to change our privacy policies described in the Notice of Privacy Practices. You may obtain a current notice on our website, www.drpstokes.com, or ask the receptionist, or contact us by mail.

In addition, the patient hereby authorizes Iberia Gastroenterology Associates, Inc. to release any and all medical records, including diagnosis related to alcohol and drug abuse and/or mental disorders, and billing information to the Social Security Administration, Medicare, Medicaid (or their various intermediaries), the patient's insurance company, health maintenance organization, workers compensation carrier, employer, persons acting on behalf of a preferred provider arrangement (or any of their agents or representatives), or any other individual, entity, agency or organization obligated to pay any medical expense for and on behalf of the patient **when such information is requested for payment or coverage determination purposes**. The patient understands that their medical information may be mailed, faxed, or electronically transmitted, and that the faxing or electronic transmittal may increase the risk of unintentional disclosure of such information to third parties. The patient agrees to voluntarily assume such risk in consideration of the benefits of enhanced treatment and payment resulting therefrom, and expressly authorizes such transmission releasing Iberia Gastroenterology Associates, Inc. from any liability resulting from such transmission. The patient understands that he may revoke this consent at any time by a request in writing. If he/she does revoke the consent, Iberia Gastroenterology Associates, Inc. can refuse to treat him/her. While this consent may be revoked, it cannot be retroactive to the release of information made in good faith.

Upon receiving any inquiry as to the presence or general condition of the patient, Iberia Gastroenterology Associates, Inc. may (unless otherwise requested by the patient, next of kin, or doctor) release at its discretion, the patient's name, address, age, and sex, general nature of inquiries, or the general condition of the patient.

This authorization shall remain in effect for a period of not more than one year from the date shown below or until payment of this account is rendered in full, whichever is longer. The patient hereby consents to such release of information and releases and relieves Iberia Gastroenterology Associates, Inc. from any and all legal liability that may arise from the release of this information.

Assignment of Benefits

I hereby irrevocably assign and transfer to Iberia Gastroenterology Associates, Inc. any and all benefits to which I am entitled or which are available to me under any medical, health and accident, or workers' compensation policy, plan, or program. I hereby authorize and direct that any such payments be paid directly to Iberia Gastroenterology Associates, Inc. I hereby further assign and transfer to Iberia Gastroenterology Associates, Inc. any and all rights under La. R.S. 22:657(A), La. R.S. 23:1201.2,29 USCA 1132, or any similar statutes for penalties, attorneys fees and costs for failure of any insurance company, or medical, health and accident, or workers' compensation policy, plan, or program to timely pay a claim for services rendered to me. I further authorize and agree that a carbon or photostatic reproduction of this assignment shall be effective as an original. I also authorize any overpayment due to me on this account, first be credited to any outstanding patient share balances that I have incurred. Should my account be referred to a collection agency for collection, I will assume responsibility for all collection and/or attorney fees incurred.

Privacy Notice

I hereby give consent to Iberia Gastroenterology to use and disclose my protected health information for the purposes of treatment, payment and health care operations. I have received a copy of Iberia Gastroenterology's Notice of Privacy Practices which provides detailed information about how Iberia Gastroenterology Associates, Inc. ***may use and disclose my protected health information and by agreeing to the terms provided therein will consent to my protected health information being shared with a Health Information Exchange****. I understand that I have a right to request a restriction of how my protected health information is used and/or disclosed, but that request must be in writing, that Iberia Gastroenterology is not required to grant my request, but if Iberia Gastroenterology does grant the request, it will be binding.*

The patient has read and understands all of the above and also acknowledges receipt of the Notice of Privacy Practices.

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Patient's Legal Name	Patient/Responsible Party Signature	Date