Katy Rheumatology & Associates, P.A.

DUE TO LAWS ENACTED BY CONGRESS, WE ARE REQUIRED TO HAVE YOU SIGN THIS CONSENT FORM PRIOR TO RECEIVING TREATMENT

Do you consent to medical examination and any other procedures or tests deemed necessary by

Dr. Padma Chimata while you are receiving medical care from our office?

YES_____ NO_____

Do you consent to our staff releasing medical and insurance information to a third party? (Specialists, Insurance Verification, Prior Authorization, Research purpose only)? YES_____ NO_____

Do you consent to our office mailing bills to your home? YES_____ NO_____

Do you consent to our staff leaving messages on an answering machine or voice mail system regarding appointments and/or test results? YES_____ NO_____

Do you consent to our staff releasing information about appointments and/or test results to the person(s) assigned on your list? YES_____ NO_____

Please list the name(s) of the person(s) to whom we can discuss your medical information with:

1. NAME:_____RELATIONSHIP_____
2. NAME:_____RELATIONSHIP_____
3. NAME:_____RELATIONSHIP_____

NAME:_____Date:_____Signature:_____

Initial here_____if you wish this consent to be effective indefinitely or until you revoke it.

(if not initialed you will have to sign a new form every time)

Initial here_____if you DO NOT give permission to release your medical information to anyone but yourself.

Name:_____Date:_____Signature_____

You may revoke this consent at any time. By revoking this consent, you will receive no further medical care from Katy Rheumatology & Associates. Revoking consent for further treatment does not relieve you from any financial obligations which occurred during the period this consent was effective.