3940 Oakwood Hills Parkway, Suite #2
Eau Claire, WI 54701

General Consent for Evaluation and Treatment

I consent to a provider, or other designees as deemed necessary, to perform reasonable and necessary medication examination, testing and treatment for the condition which brought me to seek care at this practice or one that has been identified. I understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Notice of Physician Ownership

I have been made aware of physician ownership in Oakleaf Surgical Hospital, a federally recognized "physician owned" specialty hospital. I have been made aware that there are alternative health care facilities available to me to receive medical treatment and/or services.

HIPAA Written Acknowledgement of Receipt

I acknowledge that I have received the Notice of Privacy Practices from Eau Claire GI Associates as a new patient and annually thereafter. Listed below are persons that I will permit access to my medical information such as appointments, treatment and questions pertaining to my bill.

☐ I do not consent for anyone to have access to my medical records or information pertaining to my care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ The patients condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

Signature of Patient Name or Personal Representative: _____

Patient Name (printed): _____ Date: _____

If Personal Representative, describe relationship to patient: _____