

COASTAL VASCULAR & INTERVENTIONAL CONSENT FORM

_____ I authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. The nature and purpose of the procedure, possible alternative methods of treatment and risks involved and the possibilities of complications have been fully explained to me.

_____ I authorize payment of medical benefits to Coastal Vascular & Interventional for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ I authorize the release of the results of my care at Coastal Vascular & Interventional to my primary care physician and my referring physician.

_____ I acknowledge that I have received a copy of Coastal Vascular & Interventional Notice of Privacy Practices.

_____ I acknowledge that I have received a copy of Coastal Vascular & Interventional Patient's Rights.

You may release my PHI to: (Family members): _____

Patient, Parent or Guardian Signature Date

Relationship to Patient (if not signed by patient)

Witness Signature Date