100 Market Place Blvd Ste 207
Cartersville, GA 30121

1690 Stone Village Lane, Ste1001
Kennesaw GA, 30152

Patient Consent Form

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments;
- Administration of any needed anesthetics;
- Performance of such procedures as may be deemed necessary or advised in the treatment of this patient;
- Use of prescribed medications;
- Performance of diagnostic procedures/tests;
- Taking and utilization of cultures;
- Performance of other medically accepted laboratory testing that may be considered medically necessary or advisable based on the judgment of the attending physician or his assigned their assigned designees;

I fully understand that this 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 force until revoked in writing.**

I understand that Anu Mongia, MD A.A & S. LLC includes content at satellite offices under common ownership.

I understand that Anu Mongia, MD Allergy Asthma Sinus, LLC/ Aman Mongia, MD Center for Infectious Diseases, LLC will use and disclose my information for the purpose of treatment, payment and healthcare operations.

Treatment includes, but not limited to: The authorization and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medications; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as: diagnostic procedures, the taking and utilization of cultures, and of the other medically accepted laboratory tests, all of which the judgment of the attending physician or her assigned designees, may be considered medically necessary or advisable.

Payment includes, but not limited to: The authorization of payment directly to Anu Mongia, MD Allergy Asthma Sinus, LLC/ Aman Mongia, MD Center for Infectious Diseases, LLC or other benefits payable to me. I hereby authorize the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insures, or work related injury, to my employer or designee. I understand that I am financially responsible for charges not covered.

Healthcare Operations include, but not limited to: Release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I fully understand that this Consent is given in advance of any 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. This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including, but not limited to blood-borne diseases.

I have been given an opportunity to read the Red Flag policies and procedures. **Initial___________.**
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its consents.

Patient (or Responsible Party)
Signature: ____ Date:_____________