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Patient Name (Print) _____ Date of Birth _____
First MI Last

PATIENT CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

I, the undersigned, consent to the use and disclosure of my protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. I accept that I am financially responsible for all services rendered on my behalf by Rochester Gynecologic and Obstetric Associates, P.C. (RGOA). For those insurance plans for which RGOA accepts assignment, I accept personal responsibility for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me, including attorney fees if necessary. I authorize payment directly to RGOA for services for which the Practice accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

Signature of Patient or Parent/Legal Guardian _____

Date _____

ROCHESTER GYNECOLOGIC AND OBSTETRIC ASSOCIATES, P.C.
PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Practice's Privacy Notice.

Name of Individual (Printed) _____

Date of Birth _____

Phone Number with Area Code _____

Signature of Individual or Personal Representative (Minor) _____

Relationship if Personal Representative (Guardian, Parent if a _____

Date Signed _____

Witness _____