

Krishna M. Ganti, M.D.
11373 Cortez Blvd, Suite 203
Brooksville, FL 34613

Consent/Authorization

Assignment of Benefits: I hereby assign my insurance benefits to Dr K.M.Ganti. The term “insurance refers to all types of health care insurance. I understand that Dr. K.M.Ganti will only fill those insurances, including electronic billing, that he is a Provider for, but I will be given the necessary paperwork to bill my insurance that he is **NOT** a provider for. I understand that this assignment will remain in effect indefinitely or until such a time I or my legal representative revokes this arrangement.

Medigap: I authorize payment Medigap Benefits from: _____: to Dr. K.M. Ganti. I understand this authorization will apply to all occasions of service until revoked. This office will use the list provided by Florida Medicare for Medigap companies.

Further, I understand that I am entering into a contractual relationship with Dr. K.M. Ganti, for professional care. I further understand that merit less and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Dr. K.M. Ganti, I (the patient) and/or my representative agree not to advance, directly or indirectly, any false, merit less, and/or frivolous claim(s) of medical malpractice against Dr. K. M. Ganti.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as Dr. K.M. Ganti. Furthermore, I agree that these expert witnesses will adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, I, Dr K.M.Ganti agree to the same stipulations.

Financial Agreement: I understand that I am responsible for payment, including services that are deemed non covered, or not medically necessary by my insurance company.

Use and Disclosure or Protected Health Information: With my consent Dr. K.M. Ganti may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Ganti’s Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Ganti reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Office at this location. With my consent, Dr. Ganti may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carry out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others. With my consent, Dr. Ganti may mail to home or other designated location any items that assist the practice in carry out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Ganti restrict how it uses or disclosures my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

If you would like your wife, husband, mother, etc., to be able to obtain information regarding your healthcare, please complete this section. Please Name the person. Example: Mary Healthcare.

I give my authorization for _____ to obtain any/all information relating to my healthcare.

Privacy Practices:

I have read or received a copy of Dr. K.M. Ganti’s Privacy Practices:

Initials _____

Date: _____

Signature _____

11/06/07