**CARDINAL ENDOCRINOLOGY**

www.mydoctorpete.com

1580 McLaughlin Run Road, Suite 212

Upper St. Clair, PA 15241

Tel: 412.319.7215 FAX: 412.319.7045

**I. CONSENT TO TREATMENT:**

1. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient name) consent to the provision of treatment that may include diagnostic procedures, medical treatment by CARDINAL ENDOCRINOLOGY, LLC, including its physicians and health care providers which may be considered necessary or advisable. I understand special consent forms may need to be signed for specific procedures. If I have a religious objection to specific care to be provided I may ask that such care not be provided.

2. I understand that my care may include examinations, diagnostic tests, medical treatment, taking photographs/video and making audio recordings that may be used for my care and/or for education.

3. I understand and agree that others, under the direction of Dr. Grondziowski, may assist or participate in providing medical care to me. These people may include but are not limited to residents, fellows, and medical, pharmacy, or nursing students.

4. I give CARDINAL ENDOCRINOLOGY and its designees permission to use my information as described in the Notice of Privacy Practices.

5. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

**II. FINANCIAL ARRANGEMENTS:** I agree to the following terms related to payment for services provided by CARDINAL ENDOCRINOLOGY.

1. I understand that CARDINAL ENDOCRINOLOGY does not participate in any insurance plans, and that all fees from this office are my responsibility, and that payment is due at the time of the visit. No additional payment(s) will be requested from my insurance plan.
2. I understand that my insurance information will still be collected solely for the purpose of obtaining necessary authorization for prescription medications, laboratory, imaging, and other procedures.

**III. PATIENT VALUABLES:** I relieve CARDINAL ENDOCRINOLOGY of any responsibility for loss of clothing, cellphone, money, valuables, dentures, glasses, or any other items that I decide to keep with me during my appointments. I further understand that CARDINAL ENDOCRINOLOGY will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me during my appointments.

**IV. AGREEMENT TO MEDIATE CLAIMS:** I agree that any claim which may result from the care provided to me by Dr. Grondziowski, nurses, and other health care providers in this practice shall be subject to the laws of

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Pennsylvania. I also agree that before any lawsuit is filed related to the care provided to me, I must attempt to resolve any claim through mediation, which must take place in the Commonwealth of Pennsylvania. I am not waiving my right to a jury trial. Mediation is a process in which a neutral third person tries to help settle a claim. This agreement is binding on me and any person making a claim on my behalf.

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| --- | --- | --- | --- |
| Signature of Patient (or person authorized to sign for Patient): |  | Date: |  |
| If authorized signer, relationship to Patient: |  | | |
| Witness: | asdf | Date: |  |
| Signature of Physician: |  | Date: |  |