



AKKARY

Surgery Center

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CONSENT TO TREAT

General Consent: I, the undersigned, hereby voluntarily consent to medical/surgical treatment and diagnostic workup deemed advisable to diagnose and treat my condition to be performed by Akkary Surgery Center Physicians, Associates and Staff. I am aware that practice of medicine is not an exact science and I acknowledge that no guarantees have been or will be made to me as a result of examination or treatment by this practice. I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

I understand that if there is an at-risk exposure to my body fluids, I may be tested for HIV, Hepatitis B and/or C virus. Those test results will be shared with the healthcare worker that was exposed.

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the diagnosis, care and/or treatment and I am not subject to duress or undue influence.

Financial Responsibility: I understand that I may need to call my insurance company to see if they will approve and pay for my medical care. Please bill my health insurance plan as a service to me. I am aware that this does not mean that they will agree to pay for any services. I agree to pay whatever amount is not covered if deemed to be my responsibility. (This includes all inpatient care/visits at United Hospital Centers or Preston Memorial Hospital, Commercial, Medicaid, Medicare and all branches of each insurance company) I hereby authorize payment directly to Akkary Surgery Center. I certify that all information given to me in applying for payment by any third party is true and accurate. I authorize Akkary Surgery Center to release any medical information requested by representatives of local, state, federal agencies; insurance companies; or other organizations as to comply with its pre-certification, continued stay and or billing requirements. I authorize Akkary Surgery Center to request reconsideration or other appeal of a decision rendered by my insurance plan not to pay for the medical rendered or recommended to me. If I pay more than what I owe for this medical service, I agree that it can be used to pay for any unpaid bills I have with Akkary Surgery Center. I give my permission to be called on any of the telephone numbers I have given. This includes calls with pre-recorded message, automatic dialing system or artificial voice. Calls may be made by businesses helping Akkary Surgery Center collect money that I owe. I agree that my information be shared with collection agencies if I fail to pay my balance in 90 days.

I agree to update Akkary Surgery Center with all new insurance information. I understand that if my insurance is not active at the time of service, I am responsible for the payment in full.

This contract is considered valid until termination of Dr. / Patient relationship for any reason.

I understand and agree with the above consent.

Print Name: _____ **Date:** _____

Signature of Patient or Authorized Person: _____

Akkary Surgery Representative Name: _____ **Date:** _____

Signature of Akkary Surgery Representative: _____