Surgical Specialists of Trinity, PA

PERMISSION TO TREAT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by Surgical Specialists of Trinity, PA, deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature:____ Date:_______________________

AUTHORIZATION AND ASSIGNMENT

I request that the payment of Authorized Insurance Benefits/Medicare be made to me or on my behalf for any services furnished by Surgical Specialists of Trinity, PA. I authorize any holder of medical information about me to release to Insurance Carriers/CMS and its agents any information needed to determine these benefits related to services. I hereby authorize Surgical Specialists of Trinity, PA to furnish information to Insurance Carriers/Medicare concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) Insurance Carrier(s)/Medicare to make payments directly to Surgical Specialists of Trinity, PA for medical/ diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency for any returned checks. I understand that other Insurance Carriers and/or Medicare may not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this practice's office for service. I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Signature:____ Date:_______________________