Consent for Treatment

Name:

Date:

I know that I have a health problem that requires diagnosis and/or treatment or surgery. Therefore, I voluntarily consent to my admission and treatment at Belmont Surgery Center, L.L.C. I authorize the release of any medical information to process insurance cairns related lo this admission.

I am aware that my physician may have ownership interest Belmont Surgery Center, L.L.C. If I chose to go to another health care facility for this procedure, it will not adversely affect my relationship with mv surgeon.

For purposes of quality and peer review, I authorize Belmont Surgery Center, L.L.C. to allow their representatives to review my surgical chart and associated documents.

Assignment of Insurance Benefits

I hereby authorize payment directly to Belmont Surgery Center, L.L.C. of the health insurance benefits otherwise payable to me during this or any further hospitalization. I acknowledge that I can reverse this authorization at any time. Within 24 hours, a claim will be filed with your health insurance carrier. You will be notified when final action (payment, denial, etc.) has been received.

Signature of Patient or Personal Representative if the Patient is a Minor

Date

Printed Name of Patient or Personal Representative

Relationship of Personal Representative to the Patient