8142 Bellarus Way, Suite 101, Trinity, FL 34655

Consent for Treatment and Payment Agreement

I _____ (name of patient), agree and consent to receive a surgical evaluation and medical treatment provided by practitioners at Minimally Invasive Surgical Specialists, LLC. Treatment includes but is not limited to the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medications, the performance of such procedures as may be deemed as necessary or advisable in the treatment of the patient such as diagnostic procedures, the taking and utilization of cultures and of other medically necessary laboratory tests, all of which in the judgement of the attending physician or the assigned designee may be considered medically necessary or advisable.
Patient initial_____

Payment includes but is not limited to the authorization of payment directly to Minimally Invasive Surgical Specialists, LLC, of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to the third-party entities or authorized persons to whom describes is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury/personal injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be absorbed electronically and made available through computer networks.
Patient initial_____

I understand there will be a $50.00 fee for all returned checks.
Patient initial_____

FOR MEDICARE PATIENTS ONLY
MEDICARE PART B SIGNATURE AUTHORIZATION – LIFETIME

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organizations furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.
Patient initial____

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of the above named individual and am authorized to initiate and consent for treatment on the behalf of this individual.
Patient name:_____ Signature:_____

Relationship to patient_____ Date:_____

A Non-Disparagement or Protection of Reputation clause restricts individuals from taking any action that negatively impacts an organization, its reputation, products, services, management or employees.

Patient initial____

Signature:_____ **Date:_____**