GERIG SURGICAL ASSOCIATES

GENERAL • VASCULAR • BARIATRIC SURGERY

Consent to Treat

Your health information is protected by federal law and it is important to us that private information about you is shared only in the manner that you wish, and only with those with whom you would wish us to share it.
The following sections pertain to your consent for us to communicate and share your private information. They are optional, and you are not obligated to give us permission to share your information.

Please read the following sections and sign the bottom to allow us to treat you and file claims with your insurance:

Consent to Treat: I request and give consent to my physician to provide and perform such medical/ surgical care, tests, procedures, drugs, and other services and supplies as are considered necessary or beneficial by my physician for my health and well-being. I acknowledge that no representations, warranties, or guarantees as to the results or cures have been made to me or relied

Infectious Disease Testing: I agree to allow Gerig Surgical to send me for testing for infectious diseases including hepatitis and human immunodeficiency virus (HIV) and that these tests may be ordered by a Gerig Surgical Physician if one of my care givers is exposed to my blood or body fluids. There is no cost for post- exposure testing.

Medicare Certification (For Medicare recipients only): I certify that the information given by me in applying for payment under the TITLE XVIII of the Social Security Act is correct. I authorize my physician who treats me to release information from my record to the Social Security Administration and/ or the Medicare program or its intermediaries or carriers. I request that payment of authorized benefits be made directly to the physician treating me, on my behalf.

Authorization for Consent to Treat a Minor (please check one):

___ My child, regardless of age, must have parent/ guardian present to receive treatment.

___ My child, aged 16 years and older, may be treated without the presence of a parent and/or guardian (this does not cover routine vaccinations).

___ I acknowledge my child, under the age of 16, must be accompanied by an adult. This adult must be 18 years of age or older, provide photo identification and is listed on registration below.

___ Designated individual(s) listed below (must be 18 years of age or older) may give consent for my child:

Name _____ Relationship _____

Name _____ Relationship _____

These above individuals may give consent for the following Medical Treatments : (check all that apply)

___ Vaccinations ___ All surgical and medical treatment deemed necessary by the provider

_____ (initials) I acknowledge that any individual accompanying a minor that is not listed above will require written consent from parent/ guardian and photo identification.

I declare that the information I have given on this form is correct to the best of my knowledge:

Signature_____**Date**_____