Consent to Treatment

SWAT Surgical Associates, L.L.P.

CONSENT TO TREATMENT:

I (the patient/parent/guardian/legal representative of the patient acting on the patient's behalf) give permission for medical treatment, including radiological and laboratory procedures, to be performed by the physicians and staff of SWAT Surgical Associates, L.L.P. (Center). This consent is valid from this date forward.

Relationship to Patient: ❑ Self ❑ Child ❑ Dependent ❑ Other _____

Printed Name	Signature	Date
Printed Name of Witness	Signature of Witness	Relationship to Signer

FINANCIAL AGREEMENT:

The person signing below agrees, whether he/she signs as patient or representative of the patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Center at the regular rates and terms of the Center. Should the account be referred to an attorney for collection, the person signing below shall pay reasonable attorney's fees and collection expenses.

"I assign payment for the unpaid charges for certain medical treatment furnished by the physicians and staff of SWAT Surgical Associates, L.L.P. and by attending physicians for whom the Center is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance at the time of services rendered."

Printed Name	Signature	Date

ASSIGNMENT OF BENEFITS:

In consideration of services rendered, I hereby assign to SWAT Surgical Associates, L.L.P., and/or any physician who has treated me, all rights, title, and interest in any payment due me for services described herein as provided in the policy, or policies, of insurance. I agree to pay the charges of the Center and/or attending physician which is greater than the amount paid by the insurance company or companies.

Printed Name	Signature	Date

MEDICARE AND/OR MEDICAID CERTIFICATION: (If applicable)

The person signing below certifies that he/she has read this document, and is the patient, or is duly authorized by the patient as the patient's representative, to execute the above and accepts its terms.

"I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Administration is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries/carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf."

Relationship to Patient: ❑ Self ❑ Child ❑ Dependent ❑ Other _____

Printed Name	Signature	Date
Printed Name of Witness	Signature of Witness	Relationship to Signer