The ENT Center of Central Georgia

Surgery Center • Georgia Hearing • Allergy Center • Voice & Swallowing Center
540 Hemlock Street • Macon, Georgia 31201
(478) 743-8953 • Fax (478) 743-1963

CONSENT TO MEDICAL TREATMENT

In consideration of medical services to be rendered to me (herein referred to as Patient) at The ENT Center of Central Georgia and/or Central Georgia Head and Neck Surgery Center (herein referred to as ENT), Patient does hereby consent as follows:

1. Consent and Treatment Authorization

Patient (or the undersigned acting on behalf of Patient), who is requiring medical treatment, does hereby consent to the rendering of such care and treatment, which may include diagnostic procedures and such medical treatment and care as the Attending Physician or other physicians of the ENT medical staff consider to be necessary and appropriate.

The consent to receive medical treatment includes, but is not limited to, examinations, diagnostic and therapeutic procedures, medications, infusions, transfusions of blood and blood products, surgery, anesthesia and any other medical treatment and services which Patient may require.

In the event that ENT should decide that blood specimens should be provided by the Patient for testing purposes in the interest of the safety of those with whom Patient may come in contact, Patient does hereby consent to such blood withdrawal and for the testing thereof, as well as to the release of test information where this is deemed medically appropriate or required by law.

2. Disclaimer of Guarantee

Patient hereby acknowledges that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury and of adverse results. Patient hereby acknowledges that no guarantees have been made to Patient or those acting for Patient as the results of procedures which Patient may undergo while a patient of ENT.

3. Acknowledgments of Patient

Patient understands that:

a. It is customary, absent emergency or extraordinary circumstances, that no substantial or invasive medical procedures be performed upon a patient unless and until the patient has had the opportunity to discuss these procedures with the physician or other health professional so that the patient may be informed of the contemplated procedures.

b. Each patient has the right to consent,or refuse to consent to any specific procedure or therapeutic course of treatment. If Patient refuses consent to the administration of blood or blood products, ENT reserves the right to decline to provide medical care if, in the opinion of the Attending Physician, the refusal of blood products poses a serious threat to the Patient.

4. Patient Understanding of Consent

This Consent Form has been adequately and fully explained to Patient, and Patient, by his or her signature, indicates satisfaction as to an adequate understanding of this Consent and of its significance and that Patient is voluntarily executing the same.

5. Authorization for Release of Medical Information

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/ AIDS confidential information to other physicians for continuity of care issues.

6. Assignment of Insurance Benefits

For value received, I hereby irrevocably transfer, assign and set over to ENT all insurance benefits of every kind and description, which benefits would be payable directly to me except for this assignment, and not to exceed ENT's regular charges for the medical care given me. ENT reserves the right not to accept assignment of such benefits at its discretion. I also extend all appeal rights to ENT for any and all issues related to utilization review and management and claim payment or denial.

7. Guarantee of Account

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to payment of those fees and charges not directly reimbursed to The ENT Center of Central Georgia or Central Georgia Head and Neck Surgery Center by any insurance policy, self-insurance program or other benefit plan

I understand and acknowledge that it is my sole responsibility to obtain any required referral number prior to my visit. If I do not obtain such number, I will be responsible for all charges related to services rendered on my behalf.

I hereby authorize ENT or Central Georgia Head and Neck Surgery Center to provide such information as may be required by State or Federal agencies, and for and in consideration of the services rendered to patient, we, the under-signed, jointly or severally, promise to pay ENT or Central Georgia Head and Neck Surgery Center the full amount of charges for such services, on demand, or by such future date as may be determined by ENT. I understand that my bill will be due and payable in full on or before such date. I understand that, in the event account is not paid in full by such date, there will be added to my balance a Late Charge of one and one half percent (1 1/2%) per month on the outstanding unpaid balance,. I understand that the application of the Late Charge will begin on the 61st day after the date of service, regardless of the status of any insurance claims. I further understand that, should it become necessary to collect my debt through an attorney at law or a collection agency, that late charges will continue to accrue until the debt is paid in full.

8. Validity of Consent

This consent is valid during the entire term of my association with ENT Center of Central Georgia and/or Central Georgia Head and Neck Surgery Center may be relied upon by ENT unless, and until, revoked by Patient, in writing.

Date ______________________ Patient/Guardian ______________________

Relationship to Patient ______________________