SOUTHEASTERN PENNSYLVANIA ORAL SURGERY

☐ EPISCOPAL HOSPITAL
100 E. Lehigh Avenue
Philadelphia, PA 19125
(215) 707-3613
(215) 707-5405 Fax

Consent for Treatment and Authorization to Pay Benefits

Consent for Treatment:
I hereby generally consent to the rendering of care, which may include routine diagnostic and therapeutic procedures, as the attending physician and such associate assistants and other health care providers deem necessary.

I understand that:
A) It is customary, except in case of an emergency or extraordinary circumstances, that no surgical or invasive procedures are performed upon a patient unless and until he/she has had an opportunity to discuss them with the physician or other health professional.
B) Each patient has the right to consent; or to refuse consent, to any procedure without his/her full knowledge and consent. I understand the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as a result of examination or treatment in this office.

Authorization to Pay Benefits:

Medicare Patients

I request that payment under the medical insurance program be made to Southeastern Pennsylvania Oral Surgery, LLC, on all future bills for services rendered to me by Southeastern Pennsylvania Oral Surgery, LLC. I authorize Southeastern Pennsylvania Oral Surgery, LLC to release to the Health Care Financing Administration, or such other secondary payors and their agents, any medical information needed to determine these benefits, or the benefits payable to related services.

Commercial Insurance Patients

I authorize that any insurance benefits for services and/or medical care rendered by Southeastern Pennsylvania Oral Surgery, LLC, or its designees be released by the insurance carriers or others who are financially liable for services and/or medical care, to Southeastern Pennsylvania Oral Surgery, LLC, or its designee all medical records and other information needed to substantiate payment for such. I also authorize Southeastern Pennsylvania Oral Surgery, LLC or its designee, to release to Insurance carriers or others who are financially liable for services.

Payment Guarantee

I, and the undersigned agree to assume full financial responsibility, and to personally guarantee payment of all charges hereafter incurred at Southeastern Pennsylvania Oral Surgery, LLC, and not paid for by third party payors. This payment is expected to be made within 30 days of notification of any balance not paid by the third payors. I understand that if this bill is not paid within this period of time, that the account may be turned over to the designated collection agency.

I certify that I have read and fully understand the above.

Patient/Guarantor Signature	Date
Guardian/Next of Kin Signature	Relationship
Witness	