436 Nokomis Avenue South
Venice, FL 34285
Phone 941-488-7742
Fax 941-484-7756

Sidney W. Holec, M.D., F.A.C.S.
Bryan L. Smith, M.D., F.A.C.S.
Issam A. Halaby, M.D., Ph.D., F.A.C.S.
Christopher M. Willkomm, M.D.

Patient Last Name _____**First Name** _____**MI**_____

Consent to Treatment

I am presenting myself for medical and/or surgical treatment to Surgical Associates of Venice & Englewood and I voluntarily consent to the rendering of such care, including diagnostic tests and medical treatment, by authorized agents and employees of Surgical Associates of Venice & Englewood, physicians, or their designees, as may in their professional judgment be deemed necessary or beneficial to my well being.

I understand that when the physicians treat me in the hospital, wound care center, or surgery center that they are functioning as independent contractors and will bill separately from those facilities or from other physicians who treat me in those facilities. I understand that the physicians are not employed by those facilities and that they are independent contractors who have been granted the privilege of using the hospital / medical facilities for the care and treatment of their patients.

I understand that examination and treatment received on an emergency basis is not intended as a substitution or replacement for complete medical care.

Medicare Certification Release

I certify that the information given by me in applying for payment under the Title XVIII and Title XIX 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 request that payment of authorized benefits be made on my behalf to Surgical Associates of Venice & Englewood.

Insurance Assignment

I hereby assign to and authorize Surgical Associates of Venice & Englewood and it's physicians involved in my care during this period of illness and treatment, or their duly authorized assigns to take all necessary steps, without limitations, to insure that any insurance benefits otherwise payable to me or my estate are paid directly to Surgical Associates of Venice & Englewood. This assignment of benefits includes but is not limited to billing insurance, filing petitions, filing suit, in my name or on behalf of the physicians, filing proofs of claim, filing probate claims and filing grievances and all other similar procedures, as may be amended from time to time with the state department of insurance. I also agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the other purposes.

Fraud

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, or files a statement of claim containing false, incomplete or misleading information may be subject to prosecution under applicable law.

_____ _____

Signature of Patient or Legally Authorized Representative Printed Name of Person Signing

Date _____