

**Treatment, Payment,
Operations
Consent/Acknowledgement**



Children's Surgical Specialty Group, Inc.

Consent For Treatment

I hereby consent to treatment by Children's Surgical Specialty Group, Inc. and/or affiliated medical staff members on behalf of my minor child/children, and myself including stepchildren. I understand that during treatment, the possibility exists for health care workers to become directly exposed to the individual's blood or body fluids. The law authorizes health care providers to test patients for HIV antibodies, deemed consent, when the health care provider is exposed to the body fluids of a patient. In the event of exposure, I understand that I will be deemed to have consented to testing, and consent to release test results to the health care worker who may have been exposed. Prior to testing, I will be informed and given an opportunity to ask questions.

Obligation of Payment

I direct and assign payment from my insurance company to Children's Surgical Specialty Group, Inc. I understand that my insurance policy is a contract between my insurance company and me, and that I am responsible to Children's Surgical Specialty Group, Inc. for any charges not covered by my insurance including co-payments, deductibles, and fees for non-covered services. Upon default on any payment due to Children's Surgical Specialty Group, Inc., I agree to pay all cost of collections including collection agency fees of 33-1/3% or any attorney's fee of 33-1/3%. Some insurance plans (i.e., Medicare, Blue Cross, Tricare, and Sentara) require that lab work be billed by the laboratory performing the testing. In these instances, I understand that I will receive a separate statement and bill from the lab performing the test.

Balances Due and Billing Questions

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Charges not billed to my insurance company are due prior to leaving the office (i.e. co-payments and deductibles). I have been informed that a fee of \$25.00 will be applied to my account for any returned checks. The RETURNED CHECK FEE is only payable in cash or by money order. Please direct all billing inquiries to Billing Representative at the practice where you received your care.

Acknowledgments/Certifications

I the Parent/Legal Guardian/Patient acknowledge that;

- I was provided with a copy of the "Patient/Family Rights & Responsibilities" and given an opportunity to ask questions about the information provided.
- I acknowledge that I was provided a copy of the "Notice of Privacy Practices" and given an opportunity to ask questions about the information provided.
- I have read and agree to the terms of the "Patient Financial Policy". I certify that I understand the contents of this form.

Thank you for selecting Children's Surgical Specialty Group, Inc. as your Health Care Provider

PATIENT NAME (please print)

DATE OF BIRTH

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SIGNATURE OF PATIENT/LEGAL GUARDIAN

RELATIONSHIP TO PATIENT/LEGAL AUTHORITY

DATE

Witness: _____

Date: _____