1046 Cypress Village Blvd, Sun City Center Fl, 33573 813-633-0081
www.absolutesurg.com

FINANCIAL CONSENT

Patient Name: ____________________________ DOB: ____________________ Date: _____________

I hereby authorize said assignee to release all information necessary to secure payment. I certify that the information given by me for payment by my insurance plan (s) is correct. I authorize any medical holder or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services or authorize such physician to submit claim to the above insurance company for payment to me.

I understand that I am financially responsible for all charges whether or not paid by my insurance, including any deductible and co-pays, and that the payments are due at the time service rendered.

I understand and agree that in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney or a collection agency, and I agree to pay collection agency's fee for collection of **20%**, court costs, and/or reasonable attorney's fee that might incurred in the collection of any outstanding balance. I authorize the physician to release any information necessary to allow payment of any claim or any information acquired in the course of my examination or treatment to my referring physician. I understand and agree if I do not keep my appointment or fail to give **24 hour notice** of appointment change I will be charged **$25.00** fee. This charge is not covered by insurance. **Credit Card processing fee of $5.00**

CANCELLATION POLICY

We charge $25.00 for office no- show and $ 100.00 for procedure no show. Due to the increased time and work required by some insurance companies to obtain authorization for a procedure, if you cancel an appointment after our office has obtained your authorization **(usually a week prior) there will be a 50.00 cancellation fee.**

Patient Signature: ____ _____ **Date:** ______________________

CONSENT FOR TREATMENT

I hereby voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostic and /or surgical procedures. I understand that I am under the care of the attending physician and it is the responsibility of the staff to carry out the instructions of the physician(s).

Patient Signature: ____ Date: ___________________________

MEDICATION, PATIENT REFERRAL AND COMMUNITY EXCHANGE

I hereby voluntarily consent to the rendering care physician, to view my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my provider and staff here, and it may include prescriptions back in time for several years. Electronic referrals and the capability to electronically exchange your health information

Patient Signature:____ Date: ____________________________