Surgical Informed Consent and Billing Authorization

Please review and complete the following authorization form. This document will be placed in your medical and financial record.

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1. Patient and Provider Information

Patient Full Name:

Date of Birth: MM/DD/YYYY

Surgeon Name:

Proposed Surgical Procedure:

Date of Procedure: MM/DD/YYYY

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2. Informed Consent for Surgery

I authorize the surgeon listed above, along with any designated assistants, to perform the surgical procedure described on this form. The nature, purpose, benefits, risks, and possible complications of the procedure, as well as alternative methods of treatment, have been fully explained to me.

I understand that during the course of the operation, unforeseen conditions may be encountered that necessitate additional or different procedures. I authorize the surgical team to perform such procedures as they deem medically necessary in the exercise of their professional judgment.

I acknowledge that no guarantee or assurance has been made to me regarding the results or outcome of the surgical procedure.

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3. Billing and Financial Authorization

I authorize the clinical facility and attending physicians to release any medical information required by my insurance company or third-party payer to secure payment for services rendered.

I hereby assign and transfer all medical and surgical insurance benefits directly to the provider/facility. I understand and agree that I am ultimately financially responsible for all charges, co-payments, deductibles, and any balances not covered or paid by my insurance provider.

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4. Signatures and Acknowledgement

By providing my signature below, I certify that I have read this document, have had the opportunity to ask questions, and fully understand and agree to the terms of this Surgical Informed Consent and Billing Authorization.

Patient / Legal Guardian Signature:

Relationship to Patient (if signed by Guardian):

Date signed: MM/DD/YYYY

Witness Signature:

Witness Printed Name:

Date signed: MM/DD/YYYY