Tavares Surgery LLC

1878 Mayo Drive | Tavares, Florida 32778
Phone (352) 508-5401 | Fax (352) 508-5403

Patient Name: DOB: MRN: DOS:

1. **Consent:** I request and authorize medical and surgical treatment as may be deemed necessary and appropriate by the physician and his assistants participating in my care. This care may include diagnostic, radiology and laboratory procedures, anesthesia, therapeutic procedures, drugs, medical, nursing and facility care. I understand I will sign a separate informed consent for the surgical procedure and anesthesia services.

2. **Release of Information**: I authorize Tavares Surgery Center and Rest Assured Anesthesia to release all pertinent information for the purpose of treatment, payment and health care operations. I understand such information may include Human Immunodeficiency Virus (HIV), AIDS Related Complex (ARC), Acquired Immunodeficiency Syndrome (AIDS), Hepatitis, substances abuse, to the extent that the release of such records is permitted under federal and state law. See Notices of Privacy Practices for further information.

3. **Valuables**: I release Tavares Surgery Center from responsibility for all personal articles which I have with me during the time I am a patient at the Facility. I understand that the Facility is not responsible for clothing, eyeglasses, dentures, jewelry, money or other personal articles of value kept in my possession while a patient in the surgery center.

4. **Payment**: I assign and authorize payment from my insurance company on my behalf directly to Tavares Surgery Center for all facility services and Rest Assured Anesthesia for anesthesia services provided to me. I certify that the information given by me in applying for or assigning payment under Medicare or Medicaid or any other insurance coverage is correct. I agree to pay, at the time of discharge or on an interim basis (agreed upon by the Facility), all charges not covered by my insurance company. I understand that it is my primary responsibility to pay the Facility all charges for services rendered irrespective of any disputes or disagreements between myself and insurance companies. I authorize Tavares Surgery Center and Rest Assured Anesthesia to release any information about me that is necessary to act on this request for payment.

5. **Relationship between Facility and Physicians:** I acknowledge that medical/surgical services at Tavares Surgery Center are provided by its employees, physicians and other health care providers; some are not employees of Tavares Surgery Center but are licensed independent practitioners who have been granted the privilege of using the Center's facilities for the needs of their patients. I understand that my attending physicians (or his/her designee) will be responsible for my care at all times.

6. **I acknowledge that I have received the following information both verbally and in writing prior to my procedure**: Patient Rights and Responsibilities, Disclosure of Physician Ownership, the surgery center's policy on Advance Directives, and Advance Directive information and forms if requested. I acknowledge I have been offered a copy of the Center’s Notice of Privacy Practices and understand my rights within them.

I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw my consent at any time.

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Patient Signature Date Time

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Witness Signature Date Time