SURGICAL ASSOCIATES OF PALM BEACH COUNTY/BOCACARE

Consent to Consult/Treatment

Patient Name: ______________________________ Date of Birth: ____________

I, ______________________________the________________________), do hereby
(patient's name) (today's date)

Voluntarily consent to care encompassing routine examination and medical treatment including administration of medications prescribed by the physician. I further consent to the performance of procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including RNs, LPNs, and medical assistants or their designees as is necessary in the medical staff's judgment.

I understand I have the right to review Surgical Associates of Palm Beach County/ BocaCare's Notice of Privacy Practices prior to signing this Consent. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Surgical Associates of Palm Beach County/BocaCare. The Notice of Privacy Practices for Surgical Associates of Palm Beach County/BocaCare also describes the rights and the duties of Surgical Associates of Palm Beach County/BocaCare with respect to my protected health information. Surgical Associates of Palm Beach County/BocaCare reserves the right to change the privacy practices described in its Notice of Privacy Practices.

I understand that this consent form will be valid and remain in effect as long as I receive care at Surgical Associates of Palm Beach County/BocaCare. I have the right to revoke this Consent in writing, at any time, except to the extent Surgical Associates of Palm Beach County/BocaCare has taken action in reliance on this Consent.

In consideration for the services to be provided to the patient, the undersigned promise(s) to pay Surgical Associates of Palm Beach County/BocaCare all amounts legally due and not paid by Medicare, third party payor, or other source on my behalf for services rendered, which payment shall be due in full at the time of service. In the event it is necessary to refer this account to a collection agency or attorney, the undersigned further agrees to pay all reasonable costs of collections, including reasonable attorney fees. If more than one individual executes this agreement, their liability shall be joint and several.

Signature of Patient or Person Authorized to consent for patient:

______________________________ Date: ______________________

******If the patient is a minor or is unable to consent, please complete the following:

Patient is a minor and is ______ years of age

Name of father ____________________ Name of mother ____________________

Patient is unable to consent because ______________________________

Signature of Closest Relative or Legal Guardian: ______________________

Relationship: ______________________