Infirmary Surgical Specialists
INFIRMARY HEALTH

Consent and Acknowledgement Agreement

A. **Consent for Treatment:** I give consent to my physician, other attending physicians, and their assistants and designees, to provide me with such medical, surgical, diagnostic, or other treatment services judged necessary and/or appropriate. This consent includes my consent for diagnostic procedures such as anoscopy, flexible sigmoidoscopy, and all medical treatment rendered at my physician's office under his/her instruction: including X-Ray, laboratory procedures, and other tests, treatments, or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in the course of treatment and diagnosis, cells, tissues, and/or parts may be removed from my body. I authorize my physician and his/her personnel to send the specimen to the lab of his choice when necessary in obtaining a diagnosis and authorize him/her and his personnel to dispose of any non-concerning cells, tissues, and/or parts that are not removed.

B. **General Acknowledgement:** I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury or even death. No guarantees have been made to me with respect to the results of my examinations or treatments. I understand that is my responsibility to follow instructions and make arrangements for follow-up care as directed by my physician. I understand that I may review and obtain a copy of my medical record, at my own expense, and that this review shall take place during regular business hours.

C. **Insurance Acknowledgements & Pre-Certification:** I acknowledge that it is my responsibility to understand my benefits of my insurance plan and its requirements when seeking treatment and /or care not provided by my primary care provider. I understand that it is my responsibility to contact my insurance company to determine if a pre-certification/prior authorization is needed for an upcoming procedure or service. I understand that if a pre-certification/prior authorization is required, it is my responsibility to notify the office prior to the procedure date.

D. **Photograph Authorization:** In connection with the medical services in which I am receiving, I consent that photographs may be taken in connection to my medical treatment. These photographs may be used for medical records only, unless in judgement of my physician, medical research of education will benefit by their use. In that event, I agree they may be used for the purposes provided and that my identity is not revealed by the photographs or by descriptive texts.

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Signature of Patient/Authorized Representative **Date**

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Printed name of Patient/Authorized Representative

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Relationship of Authorized Representative (if applicable)