Akkary Surgery Center
1100 Fort Pierpont Drive, Suite 101 Morgantown, WV 26508
Phone: 304-241-1100 www.akkarysc.com Fax: 304-983-8800

CONSENT TO TREAT

General Consent: I consent to medical care at this office. By law, I understand that if there is an at-risk exposure to my body fluids, I may be tested for HIV, Hepatitis B or C virus. Those test results will be shared with the healthcare worker that was exposed.

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the diagnosis, care and/or treatment and I am not subject to duress or undue influence.

Financial Responsibility: I understand that I may need to call my insurance company to see if the will approve and pay for my medical care. Please bill my health insurance plan as a service to me. I am aware that this does not mean that they will agree to pay for any services. I agree to pay whatever amount is not covered. I hereby authorize payment directly to Akkary Surgery Center. I certify that all information given to me in applying for payment by any third party is true and accurate. I authorize Akkary Surgery Center to release any medical information requested by representatives of local, state, federal agencies; insurance companies; or other organizations as to comply with its pre-certification, continued stay and or billing requirements. I authorize Akkary Surgery Center to request reconsideration or other appeal of a decision rendered by my insurance plan not to pay for the medical rendered or recommended to me. If I pay more than what I owe for this medical visit, I agree that it can be used to pay for any unpaid bills I have with Akkary Surgery Center. I give my permission to be called on any of the telephone numbers I have given. This includes calls with pre-recorded message, automatic dialing system or artificial voice. Calls may be made by businesses helping Akkary Surgery Center collect money that I owe.

I agree to update ASC with all new insurance information. I understand that if my insurance is not active at the time of service I am responsible for payment in full.

This contract is considered valid until termination of Dr. / Patient relationship for any reason.

I understand and agree with the above information.

Print Name:_____ **Date:**_____

Signature of Patient or Authorized Person:_____