Endoscopy Center of Silicon Valley

Informed Consent to Treat and disclose information

***To our patient**:*
You have the right as a patient to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be performed so that you may make the decision whether or not to undergo the procedure after knowing the risk and hazards involved. This disclosure is an effort to make you better informed so you may give or withhold your consent for the procedure.

I hereby consent to the performance of operations and procedures in addition to or different from those now planned whether or not arising from presently foreseen conditions, which the named doctor or his associates or assistants may consider necessary or advisable during the operation or procedure.

I voluntarily request ***Dr.*** _____ as my physician and such associates, technical assistants and other health care providers as they may deem necessary to treat my condition. I understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I voluntarily consent and authorize those procedures:

_____

_____

The undersigned agrees, whether he or she signs as agent or patient, that in consideration of the services to be rendered to the patient, he or she hereby individually obligates himself or herself to pay the account of the Facility in accordance with the regular rates and terms of the Facility. If the account is referred to an attorney or licensed collection agency for collection, the undersigned shall pay reasonable attorney's fees and the collection expenses, including agency expenses.

We may use or disclose information about to bill or receive payment for the medical treatment or services provided to you. The disclosures include releasing information: (1) to your health plan to obtain prior approval or to determine whether your plan will cover the treatment or services; or (2) to individuals or entities involved in collecting amounts owed to us.

_____

Patient signature Date Witness Time

_____

Parent/Guardian/Legal Representative Signature Date Witness Time

(If the patient is a minor or unable to sign, complete the following)

☐ Patient is a minor ☐ Patient is unable to sign because_____

I give permission for my protected health information to be disclosed for the purposes of communicating results, finding, and care decisions to the family members and others listed below:

Name:_____

Name:_____

_____

Signature of **Patient**/Parent/ Guardian/Legal Representative

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