General Consent and Release of Information

1. CONSENT TO MEDICAL CARE AND TREATMENT

While at Bismarck Surgical Associates, LLC, I consent to all medical and surgical care, examination and tests determined to be necessary for me. Although I expect the care given to meet customary standards, I understand that no promises or guarantees have been given to me concerning the results of my care. If I refuse treatment suggested for me, or I leave the surgery center against medical advice. I will not hold Bismarck Surgical Associates, LLC, or any individual responsible for any of the consequences.

2. RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

-I hereby authorize Bismarck Surgical Associates, LLC & Pain Treatment Center Anesthesiologists. PC to release such information in connection with this form as the surgery center in its sole discretion may deem proper. In consideration of surgery center services received or to be received for this admission / testing.
-I assign to Bismarck Surgical Associates and Pain Treatment Center Anesthesiologist, PC, all benefits herein specified, not to exceed the above surgery center charges. I further warrant that such benefits are or will be justly owing to me that no part of the same has been assigned or encumbered by me, and that said surgery center will be entitled to the full amount of its charges from the same without setoff. This assignment will be irrevocable.
-This authorization includes release of any information concerning a diagnosis of alcoholism, substance abuse, Acquired Immune Deficiency syndrome (AIDS). AIDS Related Complex, or testing for Human Immunodeficiency Virus (HIV).
-I further authorize Bismarck Surgical Associates, LLC & Pain Treatment Center Anesthesiologist, PC to release information to any hospital or Healthcare provider deemed necessary in the continuation of my care.

3. STATEMENT TO PERMIT PATIENT OF MEDICAL BENEFITS AND/OR COMERCIAL BENEFITS TO PROVIDER AND PHYSICIAN

-I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct.
-I authorize any holder of medical or other information about me to release this information to the appropriate health care carriers.
-I request that payment of authorized benefits be made on my behalf and I authorize Bismarck Surgical Associates, LLC to bill Medicare as necessary.

4. FINANCIAL AGREEMENT

I understand that I am financially responsible for all changes not covered by my medical insurance. I agree to pay Bismarck Surgical Associates, LLC; Pain Treatment Center Anesthesiologist, PC; Eye Clinic of North Dakota; and The Bone & Joint Center, P.C. for all health care services provided to me.

5. PERSONAL VALUABLES

I understand that Bismarck Surgical Associates, LLC is not responsible for my valuables.

6. NON-COVERED SERVICES

-I understand the services rendered to me may not be covered under Medicare, Medicaid, other insurance or payers.
-These may also include services which my physician determined were medically necessary for me but which later were determined unnecessary by the paying agency.
-I hereby agree that I am personally responsible for ensuring that all charges for services are paid by either myself or my insurance carrier(s).

7. CONTRACTED PHYSICIAN SERVICES

I understand that the other physicians such as radiologists, anesthesiologists and pathologists performing services for me and on my behalf are independent private physicians, and that the respective service rendered to me and the billing related thereto are independent of Bismarck Surgical Associates, LLC.

______________________________	______________________	__________
Signature of Patient or Person authorized to sign for Patient	*Witness*	*Date*

Address: Bismarck Surgical Associates, LLC. 600 North 9th Street, Bismarck, ND 58501, Phone (701)221-2299