AVS

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General Consent To Treat

Date: _____

Patient's Name: _____
Date of Birth: _____

- **Consent:** I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her assistants participating in my care. This care may include; diagnostic, laboratory or radiology procedures; anesthesia, therapeutic procedures, nursing, hospital or blood transfusions. I understand I will sign an informed consent IF surgery or surgical procedure is recommended.
- **Release of Information:** I authorize Atlanta Vascular Specialists to release pertinent information and/or copies of medical records for treatment, payment, or health care operation purposes. I understand such information may include Human Immunodeficiency Virus (HIV), AIDES Related Complex (ARC) and Acquired Immunodeficiency Syndrome (AIDS), Hepatitis, substance abuse, psychiatric/psychological services records and social work records, if any. See Notice of Privacy Practices for further information.
- **Payment:** I assign and authorize payment from my insurance company directly to Atlanta Vascular Specialists for any and all services rendered. I agree to pay, at the time of competed services all charges not covered by my insurance company. I understand that it is my primary responsibility to pay all charges for services rendered irrespective of any disputes or disagreements between myself and the insurance company.
- **No Guarantees:** I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized. I release Atlanta Vascular Specialists of all responsibility for personal articles which I have with me during the time I am a patient. I understand the office is not responsible for personal articles of value kept in my possession while a patient at the office.

I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this content will be deemed continuing and I am free to withdraw my consent at any time.

Signature of Patient: _____ Date: _____