

## **Consent to Treatment and Other Acknowledgments**

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

1. **INDEPENDENT CONTRACTORS:** Resurgens may utilize independent contractors for office, outpatient or inpatient treatment/procedures. These include, but are not limited to, surgical assistants, physical therapists, and consulting and referral physicians. Healthcare professionals that are independent contractors are not agents or employees of Resurgens and are responsible for their own actions. I understand that Resurgens shall not be liable for the acts or omissions of independent contractors. This Consent to Treatment also applies to any independent contractor utilized by my physician(s).
2. **VALUABLES:** Resurgens assumes no responsibility for, and I hereby release Resurgens from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment.
3. **AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS:** I hereby expressly authorize Resurgens and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to Resurgens and all professionals (including independent contractors) providing for such care, and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to Resurgens and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.
4. **GUARANTEE OF PAYMENT:** In return for services to be provided by Resurgens, I promise to pay and guarantee payment for services rendered to me or for my benefit by Resurgens. Such payments are due and payable upon receipt of services; however, Resurgens may elect to accept assignment of benefits from any third party payors as it deems advisable.
5. **AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS:** I authorize and release Resurgens and its employees and agents to take photographs, videos, x-rays, and/or other photographic, electronic or other images of me and to use them as may be medically appropriate. Such images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record. I understand and acknowledge that Resurgens may use cameras for security and patient monitoring, and patient confidentiality will be maintained for all such images.
6. **NO GUARANTEE OF RESULTS:** Resurgens physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment,

procedure or medical care. I release Resurgens, its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of Resurgens or its employees.

7. During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures (“procedures”) may be necessary. These procedures may be performed by physician(s), nurses, technicians, physician assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits).

A copy of this document may be utilized the same as the original.

\_\_\_\_\_  
Patient/Parent/Guardian/Authorized Representative

If not signed by the patient, please indicate relationship to the patient on the line below:

\_\_\_\_\_

Date: \_\_\_\_\_