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CONSENT TO TREATMENT AND
ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Consent to Treatment:

I know that I have the right to make decisions about my medical treatment. I consent to have my doctor and other doctors and healthcare workers of Suburban Surgical provide health care services to me, which may include, but are not limited to, diagnostic procedures, examinations, treatment, laboratory testing, medications, immunizations and other services ordered by my doctor(s). I also consent to having photographs, videos, and other electronic images of me taken and stored for treatment purposes. .

Assignment of Benefits and Financial Responsibility:

I agree the information I gave to apply for payment is correct for any third-party payers, including Medicare or Medicaid. I know I can ask for a review of my record to find out about any payments or charges I may owe if Medicare or Medicaid will not cover my charges. If I receive Medicare, Medicaid or other insurance benefits, I know I am responsible to know what my insurance covers and that I can call my insurance plan if I have questions. I also understand I am responsible for any deductibles, co-insurance, and any non-covered charges. I know that I may receive separate bills for services provided by healthcare workers who are not employed by Suburban Surgical– like a bill for laboratory testing or imaging services requested by my doctor. I authorize direct payment to Missouri Baptist Physician Services of all insurance benefits and I authorize release of my personal health information as may be required for my insurance plan to pay such benefits. I understand that I am responsible, subject to BJC's Financial Assistance Policy, for portions of my bill not covered by insurance and I understand I will be held solely financially responsible if:

- All conditions and guidelines set forth by my insurance carrier are not met
- I fail to give valid insurance information within the filing guidelines set by my insurance plan
- I receive services not covered by my insurance plan
- I am covered by a plan BJC doctors are not contracted with
- I do not have insurance

I have read this whole form, or had it read and explained to me, and I had the opportunity to ask questions.

Signature of Person Consenting to Treatment	**Relationship to Patient**	**Date**