HCA
Physician Services

the DENVER CENTER
for BARIATRIC SURGERY

GENERAL CONSENT TO TREAT FORM

I, the undersigned, hereby consent to the following:

- Administration and performance of general treatments
- Use of prescribed medications
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Denver Center for Bariatric Surgery may include consent at other satellite offices under common ownership.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize Denver Center for Bariatric Surgery practice to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Denver Center for Bariatric Surgery.

I acknowledge that I have been given Denver Center for Bariatric Surgery Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

Patient Initial _____

I, the undersigned, authorize Denver Center for Bariatric Surgery to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or responsible party) Signature Date