SHERIDAN MEDICAL GROUP

GET WELL • BE WELL • STAY WELL

1491 Sheridan Drive
Tonawanda, NY 14217
716-332-4476

Medical Consent: I hereby consent that members of the Medical Staff of Sheridan Medical Group and associates acting under the direct supervision of its Medical Staff may perform all procedures, laboratory tests and procedures, diagnostic tests and procedures, and administer such local anesthetics, medication and treatment as may be directed by my physician, or if any emergency arises, as may be directed by the physician called to be responsible for emergency care. Neither my physician nor any other person had given me any assurance as to the success of such treatment or as to the results of such treatment.

Authorization to pay insurance benefits: I hereby authorize payment of my medical and surgical insurance benefits directly to Sheridan Medical Group and/ or its member physicians. I understand I am financially responsible for any charges whether or not they are paid by said insurance. If co-payment and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Sheridan Medical Group. I authorize Sheridan Medical Group to release any information required to process all claims for reimbursement on my behalf. I also authorize the facility to apply any credit balance that may develop to another debit balance owing. A copy of this authorization may be used in place of the original.

Financial Agreement: I hereby agree, whether signing as an agent or patient, that I shall pay the Sheridan Medical Group in accordance with the rates and terms of the facility for the service(s) rendered. Should my account become delinquent, I shall pay interest at the current legal rate on any amount remaining unpaid. I also agree that if the account remains delinquent and thereby requires the services of a collection service and/or an attorney for collection, I shall pay reasonable attorney's fees and collection expenses.

Personal Valuables: It is understood and agreed that money, jewelry and other valuables are my own responsibility, and that Sheridan Medical Group shall not be liable for the loss or damage to my property.

The undersigned certifies that he/she has read the foregoing and is the patient or is duly authorized by the patient as patient's agent to execute this consent and accept its terms.
A copy of this consent is available upon request.

Patient or Guardian **Signature**: _____

Patient or Guardian **Printed Name**: _____

Relationship to patient (if applicable): _____

Date: _____