# NEWTON WELLESLEY SURGEONS, INC.

## Consent to Treatment and Authorization to Bill

**Consent to Treatment:** I, _____ *(patient's printed name)*, consent to examination, diagnosis, and general medical care and treatment (including, but not limited to, physical examinations, administration of medications, the taking of x-rays, blood draws, diagnostic tests, laboratory tests, and other minor procedures) to be performed by office personnel, including physicians, nurses, and assistants.

**Payment and Insurance Reimbursement:** I understand that Newton Wellesley Surgeons, Inc. (NWS) will bill my insurance company (including Medicare) for services provided. NWS DOES NOT accept responsibility for collecting or failing to collect insurance claims, and I acknowledge that I am ultimately responsible for payment for any services provided that is not paid by third party payors. I agree to pay any and all charges due and owed to NWS (including any co-pays and/or deductibles).

NWS and the physicians providing services to me will initiate claims for benefits (and may also process appeals from decisions related to my claims and benefits). In order to enable NWS to initiate such claims, I agree to the following:

1) I (as patient or as agent of the patient) hereby assign and transfer all rights of third party payor benefits for services rendered to me to NWS and/or its physician(s) and authorize any insurance or third party payments to be made directly to NWS and/or its physician(s).

2) I certify that the information given by me in applying for payments under Title XVIII of the Social Security Act, or under the terms of any other carriers, is correct. I request that payment of authorized benefits be made on my behalf pursuant to the above assignment. I assign the benefits payable for covered Medicare services and any other services to NWS and/or its physicians furnishing the services and authorize NWS and/or its physician(s) to submit claims to Medicare or other third party payor for payment. Any assignment of benefits is limited to the Medicare allowed charges for physician services or to an amount not to exceed NWS regular charges.

*The undersigned agrees to observe and abide by all of the statements made above.*

_____

Signature of Patient or Patient's Guardian/Representative Date

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Relationship of Guardian/Representative to Patient