



LAKESIDE SURGICAL ASSOCIATES, PA

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TREATMENT AGREEMENT

In consideration of the examination, treatment, medication, surgical procedures, anesthesia, other medical procedures and other goods and valuable consideration, the receipt of which is hereby acknowledged, the undersigned and/or his or her parent is a minor, agrees as follows:

The undersigned agrees to pay Lakeside Surgical Associates, P.A. on demand all charges incurred by the undersigned in accordance with the regular rates of Lakeside Surgical Associates, P.A. Where other sources of payment may be available, such as State and/or Federal Agencies, (under Medicare, Medicaid or their Programs) and insurance companies, Lakeside Surgical Associates, PA will aid the undersigned in determining whether care may be so covered and if appropriate, submit a claim to the appropriate agency for payment. Such submission does not, however, relieve the undersigned of payment if it is determined that such care is not covered or if such is found to be only partially covered.

The undersigned acknowledges that no representation, statement or claim has been made by anyone connected with Lakeside Surgical Associates, P.A. and that the care provided to the undersigned is, or will be covered under State and/or Federal Agencies, such as (Medicare, Medicaid, or insurance agencies). Lakeside Surgical Associates, P.A. does not make any assurances of any kind whatsoever, that the undersigned hereby releases Lakeside Surgical Associates, P.A., and its agents, servants and employees from any liability or responsibility in connection with the undersigned's potential claim of coverage under Medicare, Medicaid or insurance companies.

The undersigned does hereby request that payment be made directly to Lakeside Surgical Associates, P.A. for any Medicare, Medicaid, or insurance benefit for services rendered.

The undersigned hereby authorizes the Medicare intermediary, if applicable, to release information to Lakeside Surgical Associates, P.A. regarding the undersigned's claim for unassigned services.

Payments are to be made at the office of Lakeside Surgical Associates, P.A. and should the account be referred to an attorney for collections, the undersigned agrees to pay reasonable attorney fees, collection cost and other cost of litigation.

The undersigned authorizes such examination, treatment, medications, surgical procedures, anesthesia and all other medical procedures as may be prescribed by the physicians at Lakeside Surgical Associates, P.A.

The undersigned further certifies that he or she has fully read and fully understands all of the aforesaid information.

Date: _____

Patient: _____
(Parent, if patient is a minor)

Guarantor: _____
(Who certifies he/she is the duly authorized agent of Patient with full authority to execute this agreement)