MIRS minimally invasive & ROBOTIC SURGERY

Arturo G. Gonzalez, MD, FACS
General Surgery

Patient Signature Page

Patient Name:_____

Date of Birth: _____ Social Security #: **XXX-XX-_____**

Financial Responsibility

I have received, read and understand the Patient Financial Policy from Minimally Invasive & Robotic Surgery, PLLC and I further agree to be bound by the terms stated therein. I also understand and agree that Minimally Invasive & Robotic Surgery, PLLC may amend such terms from time to time.

Signature:_____ Date: _____

Name of Signee, if other than patient: _____

Relationship to patient (parent, guardian, aunt, etc.): _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, the undersigned, hereby acknowledge the receipt of a copy of the Notice of Privacy Practices of Minimally Invasive & Robotic Surgery, PLLC. I also acknowledge that I have been afforded the opportunity toread the Notice of Privacy Practices and ask questions.

Signature: _____ Date: _____

Name of Signee, if other than patient: _____

Relationship to patient (parent, guardian, aunt, etc.): _____