SKYVISION
CENTERS

CONSENT FOR COMANAGEMENT

I, ____________________________________, understand and accept, as part of my choice for co-management, it will be necessary for SkyVision Centers and my co-managing doctor, __________________________________, to share my patient information. I understand that by signing below, I am giving my permission for each party to share pertinent information regarding my care.

I understand that SkyVision Centers will charge $______________ for surgery and my co-managing doctor will charge $_____________ for the care I have received prior to surgery and my post operative care. For my convenience, I have asked SkyVision Centers to collect the entire fee at the time of my surgery and to send the co-management fee to my doctor accordingly. I understand, furthermore, that I have the option of paying my co-managing doctor separately, at the time of my first post operative visit.

I, hereby, grant my permission for the above, and consent to proceed with the arrangements made for my care.

PATIENT SIGNATURE:____
DATE:_______ / _______ / _______

WITNESS:____
DATE:_______ / _______ / _______

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