



PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT: I Voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting the assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment of for any and all charges that the insurance carrier declines to pay.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all part or part to the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

H.M.O. DISCLAIMER: I certify that I am not presently enrolled in any Health Maintenance Organization (HMO). Subsequent rejection of a claim as a result of this admission, due to current enrollment in an HMO plan will constitute responsibility for payment of claim on my part.

MEDICARE PATIENT CERTIFICATION – PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and or Title XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carrier, any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductible and coinsurance.

Verification of Non-Pregnancy
Date _____ File #: _____

X _____
Print patient's name

Date of last M.P. _____

X _____
Patient's signature

By my signature on this form, I do state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this relationship particular time.

X _____
Other than patient, print name and

X _____
Witness