



**CONSENT TO TREATMENT, AUTHORIZATION TO RELEASE  
INFORMATION, STATEMENT OF FINANCIAL RESPONSIBILITY AND  
ASSIGNMENT OF BENEFITS**

I authorize the facility and physician(s) to provide diagnostic and treatment services to me.

The facility and physician(s) have my permission to release any information needed for completion of their claims for payment from third-party payors including, but not limited to: insurance companies, health maintenance organizations, preferred provider organizations, government agencies and their representative.

I permit release of information concerning dates of treatment, condition, diagnosis, procedures or surgeries to my personal physician, referring physician and/or the referring facility or for follow-up care. I am aware that this authorization to release information may include information regarding HIV or AIDS, alcohol or drug abuse and/or psychiatric treatment.

\_\_\_\_\_ Please initial to indicate approval of the above paragraph.

I acknowledge financial responsibility for all facility and physician(s) fees. I understand that the physician will file my insurance claim if my physician is a participating provider with my insurance carrier and I assign direct payment to the physician all payments made under the terms and provisions of my policy. Otherwise, the physician will provide me with sufficient information to file my own insurance claim. I understand that I am responsible for and will pay my portion of the unpaid balance due for services performed by the facility and physician(s).

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_

(Consent for minors or others unable to give consent)

DATE \_\_\_\_\_

WELCOME!

Insurance Acceptance Policy: We will file your insurance claim if the patient is covered by an insurance with which we have a contract and our physician is a provider. In other cases, we require payment in full at time of service. We accept cash, check and all Major Credit Cards.

OFFICE USE ONLY: [Grid for office use]

PATIENT INFORMATION: (please print legibly)

NAME: LAST FIRST MI TODAY'S DATE

MAILING ADDRESS:

ZIP: CITY/STATE:

PHONE: ( ) DATE OF BIRTH SSN

EMAIL:

SEX: RACE: African Amer./Black Hispanic Asian/Pacific Islander Amer. Indian/Alaskan Native White (Non-Hispan1c) Other MARITAL STATUS: Single Married Widowed Separated Divorced

EMPLOYER NAME PHONE: ( )

EMPLOYER ADDRESS

EMPLOYER ZIP: CITY/STATE: OCCUPATION:

EMERGENCY CONTACT: HOME PHONE: ( )

WORK PHONE: ( )

PATIENT RELATIONSHIP TO EMERGENCY CONTACT: Child Other Spouse Friend Grandchild Parent Relative Self Significant Other

GUARANTOR / RESPONSIBLE PARTY INFORMATION (if different from patient):

NAME: LAST FIRST MI

PATIENT RELATIONSHIP TO GUARANTOR: Child Other Spouse Student Self

DATE OF BIRTH: PHONE: ( )

MAILING ADDRESS:

ZIP: CITY/STATE:

INSURANCE INFORMATION:

PRIMARY

SECONDARY

INSURANCE NAME:

POLICY NUMBER:

GROUP NUMBER:

SUBSCRIBER NAME:

SUBSCRIBER EMPLOYER PHONE: ( )

EMPLOYER ADDRESS

EMPLOYER ZIP: CITY/STATE: OCCUPATION:

PLEASE TURN FORM OVER & READ THE STATEMENT. SIGN AND DATE THE FORM.