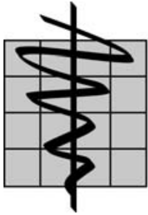

Consent to Treat/Acknowledgement of Financial Responsibility of Patient or Parent

Patient Name: ____**DOB:**_______________

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. Authority is granted to PriMed Physicians to render needed treatment and/or tests to the patient.

2. I authorize PriMed Physicians to release any information required for payment of insurance claims.

3. I authorize my insurance or Medicare benefits to be paid directly to the treating physician, realizing I am responsible to pay non-covered and unauthorized services.

4. I understand that I am responsible for all charges incurred through PriMed Physicians. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.

5. I have been given PriMed Physician's handout on missed appointments and understand my responsibilities regarding being late or absent.

6. In the event of an emergency, I designate the following person as my emergency contact:

   Name ____ Home phone ___________

   Address ___________________________________ Other phone ___________

   City/State/ Zip ____

7. Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

____ ___________

Signature of Patient or Legal Guardian **(Date)**

____

Print Name if NOT patient

____

Relationship to Patient if NOT patient