SAMPLE CONDITIONS OF TREATMENT FORM

Patient's Name:_____
Social Security #_____
Date of Birth:_____

Medical Consent: The care of the patient is under the control of the physician and the undersigned consents to any medical treatments or procedures, laboratory tests, x-ray examinations, taking of medical photographs, laboratory procedures and hospital services rendered the patient under the general and special instructions of the Your Practice physician or other physicians assisting in the care of the patient. This consent will remain in effect for one year from this date unless revoked in writing. _____
(Patient Initials)

Assignment of Benefits: I hereby assign all benefits, to include major medical and surgical, to which I am entitled, for services rendered, to the practice of _____. I understand that I am financially responsible for all appropriate charges incurred whether or not paid by said insurance(s). I agree to follow all the guidelines as set forth by my insurance plan in order to guarantee proper payment for services rendered.

_____ (Patient Initials)

Responsibility for Payment: I understand that I am ultimately accountable and responsible to make payment for all services rendered to me. I will accept responsibility to pay the balance, if any, left over after my insurance(s) has made payment on services rendered to me. I will pay for any known or expected charges at the time of the office visit unless other arrangements have been made. I agree to accept full responsibility for all charges incurred for services on days that I cannot produce proof of insurance that certifies my eligibility with the plan.

_____ (Patient Initials)

Medical Release: I authorize the release of my medical information, to other health professionals, as deemed necessary, to provide proper continuity of care. I authorize the release of my medical information to third parties to the extent necessary to ensure proper and prompt reimbursement for charges incurred. Should I become indigent, I will release all appropriate information to companies or agencies who may assist in payment of my bill.

_____ (Patient Initials)

Signature of Patient: _____ Date: _____

I, the undersigned, agree to the above statements, and authorize treatment for the patient named above.

Signature: _____ Date: _____

Relationship to the patient:_____