Patient Name_____Account #_____

GENERAL CONSENT FOR TREATMENT

I have voluntarily sought treatment for a specific illness or condition requiring diagnostic, medical or surgical procedures. I hereby do voluntarily consent to such procedures and care and to such medical surgical or other services under the general and specific instructions of Dr_____, his assistants or his designee as is necessary in his judgment.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination.

Patient Signature:_____ Date:_____

RELEASE OF MEDICAL INFORMATION

I authorize the physician indicated above to furnish treatment to me and to release information to insurance carriers concerning this illness/accident, and do hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for charges whether or not covered by insurance.

Responsible Party Signature _____Date: _____