Consent to Treat and Financial Responsibility

I hereby authorize employees and agents of Complete Care Physicians (including physicians, physician assistants and nurse practitioners and other employees and staff members) to render medical care and treatment to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____

Patient name (please print)

_____ _____ Signature of

Patient, Parent, or Legal Guardian Date

I hereby authorize payment of medical benefits directly to Complete Care Physicians and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Complete Care Physicians. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of Complete Care Physicians, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____ _____ Signature of

Patient, Parent, or Legal Guardian Date

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person (s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Signature of Parent or Legal Guardian Date