1. **Permission for Treatment:** I hereby authorize the physician and/or assistants for the care of the patient named on this record to administer treatment as may be deemed necessary including examinations or treatments that may be ordered to be performed by clinical personnel. I am aware the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me to the result of examinations or treatments to be performed.

   Initials _____

2. **Permission for Release of Medical Information:** I understand and agree that any of the above information may be used, if necessary, for purposes of the communication for appointment changes, accounts receivable, emergencies, etc. Information from any medical records may be released, if necessary for insurance purposes.

   Initials _____

3. **Assignment of Benefits:** I hereby authorize my insurance company(s) to make payment(s) as stipulated in my policy for any services furnished and that such payment(s) be paid directly to the provider of the services.

   Initials _____

4. **Payment for Services Rendered:** I also understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered and I agree to pay upon demand or as agreed for the related changes of remaining charges following my insurance payment(s). I agree to pay copays at the time of service. If private pay, I agree to pay for services in full on the date of service. I understand that if I am not able to pay my expected portion, I may be asked to reschedule my appointment.

   Initials _____

Copays due at the time of service. Private Pay or Uninsured Patients: Payment for services due at the time of service. Kindly give 24 hours notice for rescheduled or cancelled appointments. Multiple no show appointments may be subject to patient dismissal from the practice. Thank you.