

Consent for Treatment

I have read the information contained in this document and agree to abide by its terms during our professional relationship. I understand that I am responsible for payment of any fees which insurance does not pay or cover.

SIGNATURE AND DATE

PRINTED NAME

WITNESS

Insurance Authorization

I authorize the release of any medical or other information necessary to process insurance claims for services rendered. I also request payment of medical benefits to the undersigned physician or party who accepts assignment.

SIGNATURE AND DATE

PRINTED NAME

WITNESS