ALPINE WOMEN'S CENTER

PATIENT CONSENT,
AUTHORIZATION AND RESPONSIBILITY

I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.

I authorize the release of any medical and prescription medication information necessary to determine patient care.

I authorize the release of medical information necessary to determine benefits payable for insurance claims for services rendered. I agree that all proceeds of insurance are assigned to this office where applicable.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

I understand my account balance must be paid in full within 90 days of service unless other arrangements have been made with this office.

I understand that should I default on payment of my account and collection agency services are required, all costs of collections, up to 45% of the balance, including attorney/court costs will be added to the balance of my account.

______________________	______________________	______________________
Printed Name	**Patient Signature**	**SSN**

______________________	______________________
Date	**Witness**