Dallas Medical
Doctors of Internal Medicine

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CONSENT FOR TREATMENT

I voluntarily consent to such medical or surgical procedures, care, or treatments by my physician as are deemed necessary for me in his/her professional judgment. I also consent to the same with regard to his/her assistants' or designees' services rendered under his/her general or specific instructions.

I also acknowledge that the practice of medicine is an inexact science and that no guarantees can be made to mw with regard to results of diagnostic or therapeutic examinations, evaluations, procedures, or treatments.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical insurance benefits of Dallas Medical for services rendered by his/her in person or by his/her assistants under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I also understand that all laboratory tests, x-rays, radiology and diagnostic procedures, or other pathology exams, ordered by my physician, will be sent to outside facilities and could be billed separately by these facilities. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Dallas Medical to release any medical or incidental information that may be necessary for my medical care or for processing applications for insurance benefit.

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is current. I authorize release of all records on request of the authorized relevant government agency. I request that direct payment of authorized benefits be made to Dallas Medical on my behalf.

A photocopy of these assignments shall be as valid as the original.

PATIENT'S PRINTED NAME: ____________________________________ DATE: _______________

PATIENT'S SIGNATURE: _______________________________________ AGE: ________________

PARENT/GUARDIAN NAME: (If required) ___________________________________

PARENT/GUARDIAN SIGNATURE: (if required) _______________________________