Consent For Treatment

By signing below, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by this office and its healthcare providers.

In addition, the treatment I receive today will be billed to my insurance and I will be responsible for any non-covered service(s) or amounts deemed patient responsibility as dictated by my plan.

☐ I Accept

Patient or Authorized Representative Name: _____
PLEASE PRINT

Signature of Patient or Authorized Representative: _____