Conditions of services

Consent to photograph

I consent to the taking pictures of my medical or surgical condition or treatment and the use of the pictures, for purposes of my diagnosis or treatment or for the clinic's operations including peer review and education or training programs conducted by the clinic. Initial_____

Assignment of benefits

The undersigned authorizes, whether he/she signs as agent or the patient, direct payment of insurance benefits (otherwise payable to or on behalf of the patient) to the clinic. I understand my insurance carrier may not approve or reimburse my medical services in full due to the usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessary necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductible and co-insurance except where my liability is limited by contract or state or federal law. It is understood by the undersigned that he/she is financially responsible for charges not paid pursuant to this assignment.

_____ _____

Patient Name Date

_____ _____

Signature (Responsible person) Relationship