805 Columbia Rd. Suite 105
Westlake, Ohio 44145
440-250-0696

Consent for Treatment and Statement of Financial Responsibility/ Assignment of Benefits
Regina Hill MD, Inc.

I voluntarily give my permission to the health care providers of Regina Hill MD, Inc. as they deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from Regina Hill MD, Inc., or until I withdraw my consent in writing.

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of Regina Hill MD, Inc. I assign and authorize payments to Regina Hill MD, Inc. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand that I am responsible for fees not paid in full, co-payments, policy deductibles and co-insurance except where my liability is limited by contract or State of Federal law.

Signature of Patient or Guardian: _____

Date: _____

Printed Name of Patient or Guardian: _____

Date: _____

Date of Birth: _____

Relationship to Patient: _____