Consent Form for Treatment

I hereby consent to and authorize Edward and Erica Ruiz, MD Professionals as designated, to perform a physical examination and routine diagnostic procedures upon me. I also consent to and authorize Edward and Erica Ruiz, MD physicians to prescribe a therapeutic regime, which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) ordered by the Medical office physician to be performed on me despite the risk involved and complications that might be involved which were explained to me at the time that they were considered.

Patient Name:_____

Patient Signature:_____ Date:_____

Patient or person authorized to sign for patient

Acknowledgement of review of notice of privacy practices and consent for use and disclosure of health information.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I have reviewed a copy of this office's Notice of Privacy Practices.

_____ _____

Patient Name (Print) Date

_____ _____

Patient Signature Staff/Witness Signature

Financial Responsibility

I assume financial responsibility for any co-insurance, co-pay's, deductible and any balances that my insurance may not cover or may make the balance as patient responsibility. I understand that my claim will be submitted to my insurance carrier and upon the office receiving payment or denial, I will be billed for any remaining balances. I understand that if my claim goes unpaid for 40 days or more it is my responsibility to pay the medical office the total amount owed.

_____ _____

Patient Name (Print) Date

_____ _____

Patient Signature Staff/Witness Signature