

I agree (if applicable) and give permission to have the following listed persons bring my child into the practice for medical treatment. Initials

Name of individual Phone Number

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I agree to permit my child to be treated by the practice if they come in alone and are unaccompanied by a parent or other authorized person.

Name of child Parent Signature Witness Signature

By my signature below I acknowledge I have been given the chance to read a current copy of the "Notice of Privacy Practices".

Signature of patient or legally authorized individual Date

Print name if signed on behalf of the patient Date

Medicare Recipients Only – For Billing Medicare – LIFETIME AUTHORIZATION

I request that payment of authorized MEDICARE benefits be made on my behalf to the practice for any services furnished to me by the providers. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Medicare Patient Signature or legally authorized individual Date

Do you have a Living Will? YES / NO

Do you have a Durable Power of Attorney for health care? YES / NO

If not, do you wish to have additional information? YES / NO

*******These consents will remain in effect until revoked by you in writing.*******