

CHRIS B. SLATER, D.O.

CONSENT FOR TREATMENT AND PAYMENT POLICY

MEDICAL CONSENT: I consent to the procedures which may be performed during my outpatient visit(s), including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examinations and injections rendered to me under the general and special instructions of my physician. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks. I acknowledge that no guarantees have been made as to the result of examinations and/or treatments.

RELEASE OF INFORMATION: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the clinic may disclose all or part of my medical record including reports, orders and other documentation to any person or corporation which is or may be liable for all or any portion of the charges, including but not limited to insurance carriers, health care service plans, worker's compensation carriers, liability insurance companies, Medicare or welfare funds or the patient's employer. I understand that this information may or may not disclose information concerning infectious diseases or HIV.

AVAILABILITY OF MEDICAL RECORDS: I understand that my medical records will be retained for 7 years and after that point may be destroyed. I understand that for personal copies of my medical records, there will be a charge of 25 cents per page. I agree to a 30-day notice if records are needed.

PAYMENT POLICY: I understand that the charges reflect the physician's training and ability as well as the complexity of my medical condition(s). I further understand the charges are due and payable at the time of service. If I have an insurance courtesy, I understand that my co-payment and/or deductible are due at the time of service. I understand that as a service to me, the office staff will file an insurance claim on my behalf, as long as I, myself, provide all needed information. All charges are my responsibility. If I am being seen for a worker's compensation injury, or a personal accident injury without the proper secured authorization, I will be directly responsible for ALL charges at the time of service, unless arrangements have been made prior to the service. If I am more than 15 minutes late for any appointment, I will be required to reschedule the appointment for another day. If I choose to pay by a personal check and the check is returned, I will be charged \$30.00 for each check.

SIGNATURE OF PATIENT

DATE SIGNED

WITNESSED BY

DATE WITNESSED