Peter J Parker M.D.

Patient Consent, Authorization & Assignment

Patient's Name: First ______________________________ M. ___ Last ______________________________

1. I hereby consent that Peter J. Parker, MD provide me with all the health care services that, at his discretion, is necessary for my treatment.
2. I hereby authorize Peter J. Parker, MD, the release of any medical or other information necessary to the health plans, government agencies, attorneys, or their representatives for processing the claims.
3. I hereby authorize the health plans, government agencies, and attorneys to pay Peter J. Parker, MD, the medical and surgical benefits allowable as payment towards the total charges for medical treatment and services rendered. I understand that I am fully responsible for the charges resulting from my treatment, which is not covered by this assignment, and pay them promptly.
4. I am aware that upon using my health plan benefits for any services rendered by any out of network provider, I will be going out of network and exercising my "OPTOUT BENEFITS" choice.
5. I agree to hold Peter J. Parker, MD, and its professional staff free and harmless from any claims, suits for damages, or complications that may result from my treatments. I acknowledge that I have read this form and understand its contents.

Patient's Signature ______________________ Parent of Legal Guardian (if minor) ____________________

Witness ______________________________________ Today's Date ______________________________________