Donni Fleischaker
PRIMARY CARE & PEDIATRICS

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donnifleischaker.com

Consent to Treat & Financial Policy

Please read, complete, and sign. Ask us about anything you don't understand.

CONSENT FOR TREATMENT

I voluntarily consent to medical care, treatment, and services provided by Donni Fleischaker Primary Care & Pediatrics and its providers and staff, which may include examinations, laboratory tests, immunizations, and other routine procedures determined to be medically appropriate. I understand that no guarantee has been made regarding the outcome of any treatment or examination.

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY

I authorize my insurance benefits to be paid directly to the practice. I understand that I am financially responsible for any charges not covered by my insurance, including copays, coinsurance, deductibles, and non-covered services. Copays are due at the time of service. If my account becomes past due, I understand it may be referred for collection.

AUTHORIZATION TO RELEASE INFORMATION FOR BILLING

I authorize the release of medical or other information necessary to process insurance claims and obtain payment for services rendered.

ACKNOWLEDGMENT OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of the practice's Notice of Privacy Practices, which describes how my health information may be used and disclosed.

CANCELLATION POLICY

I understand that I am asked to give at least 24 hours' notice to cancel or reschedule an appointment so the time may be offered to another patient.

PATIENT NAME _____ DATE OF BIRTH _____

SIGNATURE OF PATIENT / RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____ DATE _____