Patient Name _____ Date of Birth _____

General Consent to Treat

I voluntarily consent to medical care of a routine/emergency nature from the authorized professional staff of West Erie Medical Group for myself or the above-mentioned minor for whom I am the parent/guardian. I authorize the release of any and all medical records and information obtained through my medical evaluation to those individuals that my doctor feels appropriate for my continued medical care.

I understand that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available.

It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

Financial Agreement

I authorize payment to West Erie Medical Group of any medical benefits, which would otherwise be payable to me and which were established by my insurance company. The amount paid to West Erie Medical Group shall not exceed the practice's regular charges for the services.

I also authorize the release of my medical records to my insurance ~~company/companies or other third~~ party payers or my employer as required for the collection of payments. I understand that I am responsible for the payment of charges that are not paid by my insurance company.

Medicare Agreement

The information provided by me in applying for payment of Social Security benefits is true and correct.

I also authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf.

I request that the payment of benefits be made for me. The benefits due to me for services provided by my physician shall be paid directly to West Erie Medical Group. In the event the physician does not receive such payment, I authorize such physician to submit a claim to Medicare on my behalf.

If my current policy prohibits direct payment to West Erie Medical Group, I hereby direct the check made out to me and mailed to: Regional Health Services, Inc., 717 State Street, Suite 16, Erie, PA 16501

Payment Agreement

Our office requests that you read your insurance policy and be fully aware of any limitations of the benefits provided. You should be aware that this insurance agreement is between you and the insurance company. We will gladly help you, but it is your responsibility to know the limitations of your policy. Any charge incurred beyond the reimbursement of your policy will be your financial responsibility.

I have read the above and understand my financial obligation.

Patient Signature _____ Date _____

Spouse/Guarantor Signature _____ Relationship to Patient _____

Witness _____ Date _____