CORNERSTONE MEDICAL
PATIENT CONSENT FOR TREATMENT

CONSENT FOR TREATMENT: The below stated patient hereby authorizes the performance of any medical and/or surgical procedures under local or general anesthesia which may be advised and recommended by the clinic physician while a patient at Cornerstone Medical. The patient also consents to the performance of appropriate tests for the presence of infection such as, but not limited to, infection by Hepatitis B virus or the HIV virus if deemed necessary by the clinic physician for the protection of others including the withdrawal of blood or other body fluids for this purpose.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: Cornerstone Medical is authorized to furnish medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment for my care or to any licensed physician who has accepted a referral from this office for my medical care.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all my rights under any policy of insurance including, but not limited to, major medical insurance, hospital benefits, sick benefits or injury benefits due to me because of the liability of a third party such as auto insurance or worker's compensation insurance and the proceeds of all claims resulting from the liability of a third party payable by any person, employer, or insurance company to or for the patient up to the full amount of the clinic bill. In addition, I further warrant and represent that any insurance which I assign is valid insurance and in effect and that I have the right to make the assignment. Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVI 11 or XIX of the Social Security Act is correct and request that said payment of authorized benefits be made on my behalf.

PAYMENT GUARANTEE: The undersigned agrees to pay Cornerstone Medical any and all applicable charges incurred for services rendered to the below stated patient at the time of service.

PERSONAL PROPERTY: The clinic is not responsible for personal items of a patient i.e. jewelry, cash, appliances, etc. .

The '-'ndersigned certifies that he/she has read the foregoing and is the patient or is duly authorized by the patient to execute the above and the acceptance of its terms.

X _____ _____

Patient Date

X Relation to Patient:) Spouse

Guardian or Responsible Party) Parent

) Other

X _____

Witness