CONSENT FOR TREATMENT

By signing this consent I am authorizing my provider(s), known as Dorfcorp LLC to perform all exams, tests, screenings and any other care deemed necessary or advisable for the diagnosis and treatment of my health condition. This consent is valid for each visit/telephone call made to Dorfcorp LLC unless revoked by me in writing.

Non-Covered Services: An Insurance Waiver may be required to acknowledge understanding of your responsibility to pay for non-covered services, depending on your plan. If your visit is for non-covered services, please be prepared to pay for the visit in full.

We do not file third party insurance (i.e. auto insurance, home insurance or school insurance).

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Dorfcorp LLC to furnish medical information pertinent to my health condition including, but not limited to the diagnosis, treatment and care offered or rendered to me while a patient under his/her care. I understand this information may be furnished 1) to my insurer(s) to which my medical bills have been assigned for payment; 2) as required by law, 3) for the diagnosis and/or treatment as deemed necessary by my provider(s) and/or 4) upon my written authorization on a form acceptable to Dorfcorp LLC.By signing this Consent to Release Medical Information, I agree not to hold Dorfcorp LLC its agents and/or employees, liable for any unfavorable outcomes as the result of releasing this information. I realize that release of my medical information may be necessary before my insurer(s) will cover the cost of my health treatment, and that by failing to authorize the release of this information, I may be required to pay the entire bill.

ACKNOWLEDGMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES / PATIENT RIGHTS AND RESPONSIBLITIES

I have reviewed the Office Policies , which explains how my health information may be used and disclosed. I understand that I am entitled to receive a copy of this document at my request.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the provider to release any information acquired in the course of my examination and/or treatment to my insurance carrier; and I hereby assign to the provider all payments for medical services rendered to myself. I understand that I am responsible for the payment of services. Insurance will be filed as a courtesy; however, after 60 days, if not response is received, I understand that I will be responsible for any charges. I understand that I am responsible for payment of any amount that is not covered by insurance.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the insurance carrier represented as contractually responsible for payment in whole or in part of the patient's healthcare bill, to pay directly to the provider rendering services for my care, any benefits payable for said care and/or treatment.

I agree that, should the amount paid by the insurance carrier be insufficient to cover the charge, I will be responsible for payment of the difference, and that if the nature of the illness and/or injury be such that it is not covered by the policy, I will be responsible to the provider for payment of the entire bill, unless contractual agreements have been made between the provider and the insurance company which negates responsibility.

_____ _____

Signature of patient/responsible party Date

_____ _____

Witness Date