CONSENT TO TREATMENT

For: _____
Name of Patient

1. CONSENT TO TREATMENT. The undersigned consents to health care encompassing routine diagnostic procedures and other health services rendered to the patient by Mohammad Kanakriyeh, M.D., and duly authorized agents and personnel.

2. NO GUARANTEES. It is understood that the practice of medicine and surgery and the rendering of health care is not exact science and that no guarantees have been made as to the results of treatments, examinations or other health services rendered by Dr. Kanakriyeh.

3. RELEASE OF INFORMATION. The undersigned agrees that to the extent necessary to determine liability for payment and to obtain reimbursement, Dr. Kanakriyeh may disclose portions of the patient's records, including his/her medical records, to any person or entity which is or may be liable for all or any portion of Dr. Kanakriyeh's reimbursement for charges. Special permission is needed to release this information where the patient is being treated for alcohol or drug abuse.

4. ASSIGNMENT OF BENEFITS. The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Dr. Kanakriyeh of any insurance benefits otherwise payable to or on behalf of the undersigned for treatment and health care services rendered by the patient's health plan at a rate not to exceed Dr. Kanakriyeh's regular charges. It is agreed that payment to Dr. Kanakriyeh, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood that he/she is financially responsible for charges not covered by this assignment pursuant to Paragraph 5 below.

5. FINANCIAL AGREEMENT. If the patient is not a member of an HMO at the time services are rendered, the undersigned agrees, whether he/she signs as agent or as patient, that he/she hereby individually obligates himself/herself to pay the account of Dr. Kanakriyeh in accordance with the regular rates and terms of Dr. Kanakriyeh. Should the account be referred to an attorney or collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

6. CERTIFICATION. The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative or duly authorized by the patient as the patient's general agent to execute this Agreement and to accept its terms.

_____ _____
Date and time of signing Signature Patient/Parent/Guardian/Conservator

_____ _____
Witness If signed by other than patient, indicate relationship

Financial Responsibility Agreement by Person Other Than the Patient, or the Patient's Legal Representative: I agree to accept financial responsibility for services rendered to patient and to accept the terms of the Financial Agreement and Assignment of Insurance Benefits Provisions above.

_____ _____
Date and time of signing Financially responsible party

_____
Witness