CONSENT FOR TREATMENT:
I acknowledge that I have elected on my own behalf or on behalf of my dependent to receive medical services that may or may not be covered by my health plan or any number of reasons.

I understand and acknowledge that I am financially responsible for, and therefore shall pay for, all services rendered to me or my dependent that are not paid or contractually adjusted by my insurance, in whole or in part, by my health plan for any reason whatsoever.

RELEASE OF INFORMATION:
I authorize the release of all information necessary to process my insurance claims and pertinent to my medical care. This release will remain in effect until revoked by me in writing. A photocopy of this release is to be considered as valid as the original.

ASSIGNMENT OF BENEFITS:
I assign all medical and/or surgical benefits including major medical benefits to which I am entitled, including Medicare, BCBS, HMO plans, and commercial insurance to **MMG,Atlantic Women's Medical Group,** This assignment will remain in effect until revoked by me in writing. I hereby authorize the above to release information to secure payment on my behalf.

I understand that I am financially responsible for all charges. I have read this information and understand it.

Patient Name: _____

DOB: _____

Signature: _____

Signature of Parent or Guardian (if patient is a minor): _____

Date: _____

For Internal Use Only:
Scan document once a year into Consent folder in CB

Revised 11/15