Consent Forms

Patient Name: _____ Date of Birth: ____ /____/_____

Consent for Payment

I understand that payment of all medical care is due at the time of service. I hereby assign my insurance benefits to be paid directly to Rachel Z. Chatters, M.D., Inc. I fully understand I am solely responsible for any balance not paid by my insurance.

Patient's Guardian: _____

Signature: _____

Date: _____

Consent for Care

I, the patient's legal representative, hereby grant permission to Rachel Z. Chatters, M.D. to perform medical examinations and procedures as deemed necessary/advisable for the patient's diagnosis and treatment including but not restricted to medications, lab tests, or other studies which may be used by the physician.

Patient's Guardian: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Consent for Immunizations

I, the patient's legal representative, hereby grant permission to Rachel Z. Chatters, M.D. to administer immunizations as deemed necessary/advisable for the patient.

Patient's Guardian: _____

Signature: _____

Relationship to Patient: _____

Date: _____

I have read The Privacy Act (located in the exam rooms). I have also read the consent for release of medical information that is compliant with HIPPA.

Patient's Guardian: _____

Signature: _____

Date: _____