Dr. CAREing[SM]
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Patient Registration and Consent for Treatment

Welcome to Dr. CAREing's Medical Office. Please take a moment to review and sign this Registration and Consent for Treatment. We regret that we are unable to accept any alterations to this form and will not be able to provide health care to you if the form is not signed as presented. Dr. CAREing reserves the right to make changes to this form. If changes are made, you will be presented with a new form for signature. Our clinic staff is available to answer any questions you may have.

I. Patient Rights and Responsibilities

Dr. CAREing acknowledges that I have rights as a patient and I acknowledge that I have responsibilities as a patient. These are discussed in the Patient Rights and Responsibilities and the Notice of Privacy Practices documents; copies are available to me upon request.

II. Consent for Treatment

I, ____, voluntarily present to Dr. CAREing for medical evaluation, diagnosis, and/or treatment. I consent and authorize my provider(s) or his or her designee(s) to provide diagnostic and therapeutic, which may be necessary or advisable in their professional judgment. By signing this consent form, I do not waive my right to refuse recommended tests or treatment(s).

III. Payment for Services/Assignment of Benefits

I understand that regardless of my assigned insurance benefits, I am financially responsible for payment of service rendered to me. In addition, I will be financially responsible for my spouse and my child/children that is/are born or treated by Dr. CAREing or its physicians. If the providers involved in my care accept third-party reimbursements for all or part of the services I receive, I hereby agree to assign such benefits to Dr. CAREing and authorize my insurance company, governmental program, or other entity to make payment directly to Dr. CAREing. I understand that Dr. CAREing may disclose a limited amount of health information to third-parties to obtain payment for the health care services provided.

I agree to pay co-payments, co-insurance, deductibles, and outstanding balances. Dr. CAREing will honor any arrangements and/or agreements entered into with my insurance company or third-parties payers. I understand that I will not be billed for amounts that Dr. CAREing has contractually discounted. If I am injured and receive treatment at Dr. CAREing, I agree to assign to Dr. CAREing my interest in any lawsuit or settlement to the extent necessary to fully pay Dr. CAREing for this treatment. If my account becomes delinquent and is referred to an attorney or collection agency for collections, I agree to pay reasonable and necessary attorney's fees and collection expenses.

I certify that the information given by me in applying for payment under any medical insurance program, including Medicare and Medicaid, are correct.

________________________________	________________________________	______________
Patient's Printed Name	Patient's Signature	Date
________________________________	________________________________	______________
Legal Representative's Printed Name*	Legal Representative's Signature	Date

*If signing as the legal representative, I represent to Dr. CAREing that I am the legal representative of the patient and agree to provide proof of legal representation, if requested. Should my legal authority terminate, I agree to provide written notification to Dr. CAREing.