Clifford H. Schilke M.D.

Authorization and Release

By signing this consent form, I acknowledge that I have read, understand, voluntarily consent to and authorize the following:

Authorization of Treatment: I authorize the administration and cost of all treatment and medication for myself and my dependents.

Guarantee of Payment (Self Pay): **I**nitial_____

I elect to pay in full for all services rendered. I understand that my insurance will NOT be billed.

Guarantee of Payment (Insurance): Initial_____

Assignment of benefits: I authorize payment directly to Clifford H Schilke, MD for all benefits otherwise payable to me. I understand that I am financially responsible for all charges that are not covered by insurance. I authorize Clifford H Schilke MD to submit claims to my insurance carrier as well as medical records required to evaluate these claims for payment. I understand that if my employer is responsible for all or part of this claim, they will receive the necessary medical information required to evaluate these claims for payment.

Receipt of Privacy Practices: By signing this consent form I acknowledge that a copy of the Notice of Privacy Practices has been offered/is available to me upon request.

Patient Signature_____

Date_____

Responsible Party Signature_____