



**In case of EMERGENCY please contact (Please list someone NOT living in the same household):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**SIGNATURE OF CONSENT**

**Please Read**

- 1) TREATMENT: I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME REGARDING THE RESULTS OF TREATMENTS OR EXAMINATIONS.
- 2) RELEASE OF INFORMATION: I AGREE THAT DR. SNOW'S OFFICE MAY DISCLOSE ALL OR ANY PART OF MY RECORDS TO ANY PARTY WHICH IS OR MAY BE LIABLE FOR ALL OR PART OF ANY CHARGES THAT OCCUR.
- 3) FOR CONTINUITY OF CARE, DR. SNOW'S OFFICE MAY DISCLOSE ALL OR ANY OF MY RECORDS TO ANY OTHER HEALTH CARE PROVIDER TO WHICH MY CARE MAY BE REFERRED.
- 4) I AUTHORIZE PAYMENT OF MEDICAL INSURANCE BENEFITS DIRECTLY TO DR. SNOW.
- 5) I AUTHORIZE DR. SNOW TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES, AND AGREE TO PAY THE DIFFERENCE BETWEEN DR. SNOW'S FEES AND THE AMOUNT PAID BY MY INSURANCE.
- 6) I AUTHORIZE DR. SNOW'S OFFICE TO CONTACT ME BY PHONE TO CONFIRM APPOINTMENTS AND/OR DISCUSS INFORMATION REGARDING MY HEALTH OR ACCOUNT.
- 7) I AUTHORIZE THE FOLLOWING PERSONS TO RECEIVE MY HEALTH OR FINANCIAL INFORMATION ABOUT ME: (THIS WOULD INCLUDE A SPOUSE, CHILDREN OR OTHERS YOU WISH TO HAVE ACCESS TO YOUR INFORMATION. THIS DOES NOT APPLY TO OTHER PHYSICIANS.)

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

TO REVOKE THE ABOVE, A WRITTEN REQUEST MAY BE SUBMITTED BY THE PATIENT AT ANY TIME.

- 8) ONLY THE PATIENT OR LEGAL GUARDIAN MAY REQUEST COPIES OF MEDICAL RECORDS PRODUCED BY DR. SNOW FOR PERSONAL USE. A SIGNED RELEASE OF INFORMATION AND PHOTO IDENTIFICATION WILL BE REQUIRED.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_