CONSENT FORM

CONSENT TO TREAT: I request and give consent to Luan Q. Pho, M.D. to provide and perform such medical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by Luan Q. Pho, M.D. for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Initial: _____

RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Luan Q. Pho, M.D. to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

Initial: _____

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize Luan Q. Pho, M.D. to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers for processing of claims for medical benefits. I request that payment of authorization benefits be made directly to Luan Q. Pho, M.D., on my behalf.

Initial: _____

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to Luan Q. Pho, M.D., P.A. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Initial: _____

PATIENT'S SIGNATURE _____ **DATE** _____

Parent/Guardian _____ **DATE** _____