FINANCIAL AGREEMENT, AUTHORIZATION FOR TREATMENT
AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND
AUTHORIZATION OF PAYMENT OF MEDICAL BENEFITS

_____ _____
Print patient's name Date of Birth

I authorize treatment of the person named above and agree to pay any and all fees and charges or such treatment. I agree to pay all charges for members of my family shown by statements, promptly upon presentation thereof, unless credit agreements are agreed upon in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to my family, I/we agree to pay reasonable attorney's fee or other such cost as the Court determines proper.

I will make all payments of medical expenses which are not covered by my insurance by cash or check.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof.

I authorize the release of any medical information necessary to process my family's claims and also request payment of government benefits or medical benefits from my insurance carrier(s) to Los Gatos Pediatrics.

Signature_____ Date_____
Parent/Guardian (Responsible Party)

Consent