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Insurance and Authorization Information

I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physicians. I hereby recognize the practice of medicine and surgery is not an exact science and I acknowledge that no one has made any representation, guarantee, or warranty to me regarding the results to be achieved by any treatments or examination that I (or the patient) will receive as a result of services. I authorize release of my patient records, including alcohol and drug abuse records protected under the regulations of code 42 of federal regulations, part 2 if any; psychological services, if any; social services records, if any, to my insurance company(s) for the purpose of payment of bills to my health care provider for continuity of care. I authorize and request my insurance company to pay directly to the provider the amount due for medical care. In addition, I understand that I will be responsible for any amounts that are not covered by insurance.

I understand that if any employee or physician of Karle Medical Group, P.C., sustain a subcutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound exposure to my blood or other bodily fluids, I may be tested for the Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS).

I hereby certify that the contents of this form are understood by me. Paragraphs or lines that I choose not to pertain to me, if any, were stricken and initialed by me, before I signed:

I attest that the information that I have provided on this form is complete to the best of my knowledge.

Patient Name (Please Print):_____

Patient Signature:_____

Responsible Party Name (where appropriate):_____

Responsible Party Signature:_____

* U.S. government required statistical data necessary for all healthcare entities to attain “Meaningful Use” of Electronic Health Records.
Please return this document to the Karle Medical Group reception desk upon completion