FOLSOM URGENT CARE

AUTHORIZATION TO TREAT AND ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

This content shall remain effective until: ________________________________

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff of Folsom Urgent Care licensed under the provisions of the Medicine Practice Act. It is understood that this authorization is given in advance of any specific diagnosis, treatment or care being required but is given to provide authority and power to render care which the physician on duty, in the exercise of his best judgment, may deem advisable.

Patient Name: ____

I, the undersigned, accept full financial responsibility for any portion of the bill for services rendered at Folsom Urgent Care that my insurance carrier(s) does not pay.

Signature of Patient: _____________________________________ Date: _________________

Guarantor (if other than patient): ____

Date: ___________________________

Witness: ____

Date: ____________________________