Janet D. Larson, M.D., P.C.
Maternal Fetal Medicine

PATIENT CONSENT

I hereby authorize and consent to examinations, treatments, release of medical information to my insurance company/companies, claim representative(s), adjuster(s), and other physicians by Janet D. Larson, MD, PC. I hereby assign all payments for medical services rendered to Janet D. Larson, MD, PC. I understand that all co-payments are due at the time of my appointment as in agreement with my insurance coverage. I also understand that I am personally responsible for paying the remaining balance for medical services after third party payer coverage benefits are applied. If I should be determined ineligible by any third party payer (including Medicaid); I am responsible to pay for all services rendered.

My signature verifies that I have read and understood this consent.

Printed Name: _____

Signature: _____

Guarantor's Name (if different from above):
_____

Policy Holder's Name (if different from above):
_____

Date: _____

Witness: _____

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