David Herson MD PA
CONSENT FOR CARE AND TREATMENT

Patient Name _____DOB _____/_____/_____
Date ____/_____/_____

I, the undersigned, hereby authorize David Herson MD to furnish medical care and treatment to myself. This is necessary in order to diagnose and treat my physical and mental condition.

Patient Signature _____

If patient unable to sign above:
Name of Guardian or Responsible Party _____
print

Signature of Guardian or Responsible Party _____
sign

BENEFIT ASSIGNMENT

I hereby assign all medical and surgical benefits to which I am entitled to David Herson MD PA. This includes Medicare, Medicaid, private insurance and third party payers. I hereby authorize David Herson MD PA to release any information in connection with these services (including medical records) to secure payment. This also includes attorneys, Worker Compensation adjustors. I understand that I will be financially responsible for any charges not covered by my insurance policy. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand the consent for care and treatment benefit assignment and financial policy and accept payment responsibility.

Patient Signature_____

If patient unable to sign above:
Name of Guardian or Responsible Party _____
print

Signature of Guardian or Responsible Party_____
sign