DOB_____

CONSENT TO TREAT & FINANCIAL RESPONSIBILITY

CONSENT TO TREAT

I hereby authorize employees and agents of Swiss Medical Building, LLP, including physicians, and other employees of staff members, to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing the consent, the patient will not be provided medical care except in a case of emergency.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

FINANCIAL RESPONSIBILITY

I hereby authorize payment of medical benefits directly to Swiss Medical Building, LLP and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV").I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to the physician. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of Swiss Medical Building, LLP, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date