Consent and Acknowledgement

W Brad Gates, MD, PA

Patient Name (please print) **Date of Birth**

Consent to Treatment

I hereby authorize W Brad Gates, MD and his assistants to render routine medical care to the above named patient as directed by the doctor.

The duration of this consent is indefinite and continues until revoked in writing, I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency. A photocopy or fax of this consent is as valid as the original.

Patient Signature (Guardian if the patient is a minor) **Today's Date**

Consent and Acknowledgement of Receipt of Notice of Privacy Practices and Financial Policies

I hereby acknowledge that I have been presented with a copy of the **Notice of Privacy Practices** and a copy of the **Financial Policies**. By signing below, I acknowledge that I have read both policies completely and fully understand them. I have asked questions regarding any of the above information that I did not understand and my questions were answered to my satisfaction. I consent to the use and disclosure of protected health information about the above named patient for the purpose of treatment, payment and healthcare operation. I authorize W Brad Gates, MD, PA to submit claims to the insurance company with payment to be made directly to the practice. If payment is denied, I agree to be personally and fully responsible for payment. A photocopy or fax of this consent is as valid as the original.

Patient Signature (Guardian if the patient is a minor) **Today's Date**

Witness (optional) **Today's Date**