Consent to Treatment

I_____voluntarily consent to receive any medical and health care services by Dr. Kimberly Stone and staff; including diagnostic procedures, examinations, treatments and laboratory work.

Financial Responsibility and Assignment of Benefit

It is your responsibility to know your insurance benefits (co-pay, referral, deductible and coverage.) Your insurance plan is a contract between you and your insurance company. It is impossible for our office to be familiar with all insurance plans. If you have any questions please consult your insurance company directly.

I agree to pay all charges for medical and health care services and laboratory services not covered by my insurance company.
In case of default payment, I agree to pay any and all costs of collecting this account including, but not limited to, attorney fees and court costs.

I certify that I read this for and understand its contents.

Signature of patient (or legally Authorized Person) **Date**