DATE _____

I understand that if no insurance is provided, PAYMENT IS REQUIRED AT THE TIME OF VISIT.

SHOULD INSURANCE BE ACCEPTED:

I understand that I am responsible for all deductibles and copayments not covered herein. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to the undersigned physician or supplier for service rendered.

SIGNED: _____

CONSENT FOR TREATMENT OF MINOR

I give consent for Dr. Landow to treat _____. This consent shall remain in effect unless written notification is received from the undersigned legal guardian/parent.

_____ Parent or Legal Guardian

_____ Witness