

Dr. Lorane Dick, D.O.
554 E. Foothill Blvd. Ste. 120
San Dimas, CA 91773

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

- 1) I hereby consent to, and authorize all treatment that may be considered necessary or advisable by the physician. I understand that no guarantee or assurance has been made of the results that may be obtained.
- 2) I understand that this office is a teaching facility and medical students and residents are trained at this office. When I am treated, I understand that there will be one or more students participating in my care. I have been advised that if there are some things that I am only comfortable discussing with the doctor alone, I will let her know. I understand that I am free to request more time with the doctor if I need it. I understand that if this is not acceptable to me, that the doctor will be more than happy to refer me to another physician.
- 3) I understand that payment is required at the time of visit. I understand that that I am financially responsible for all charges. I understand outside lab, x-ray and other ancillary charges will be billed by the providing facility and are not connected with this office.
- 4) I also understand that I am to give 24 hours notice if I need to cancel my appointment. I understand there is a charge of \$25.00 the second time an appointment is missed. If this agreement continues to be abused I will be expected to pay for the missed appointments from the third missed appointment. (Medical insurance does not pay for missed appointments, so you will be expected to pay for these yourself).
- 5) I have received a copy of Dr. Lorane Dick's Notice of Privacy Practices.

Date _____ Signature _____
(patient)

Authorized person _____ Relationship to patient _____

(All authorizations must be signed by the patient or by an authorized person in the case of a minor, or when the patient is physically or mentally incompetent.)