1-888-CARMEL-2
(227-6352)
www.carmelcare.net

GENERAL CONSENT FOR TREATMENT

I consent to and authorize Dr. Gary L. Berlin, of Carmel Care PLLC, to provide diagnosis, care and treatment for my condition. This consent shall be in force for this and any subsequent visits by Dr. Berlin, unless specifically revoked by the patient or authorized patient's representative.

I understand that the primary focus of Dr. Berlin's practice at Carmel Care PLLC is the diagnosis, care and treatment of acute medical conditions, and that the aforementioned services are not meant to replace routine medical care, testing or follow-up.

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me about the result of my examination or treatment.

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this form, I acknowledge that I have received a copy of the Carmel Care PLLC's HIPAA Notice of Privacy Practices and have been given an opportunity to ask questions. A copy of this consent will be included in my chart for future reference.

FINANCIAL POLICY ACKNOWLEDGEMENT

I understand that Dr. Gary Berlin, as part of his clinical practice at Carmel Care PLLC, does not accept any insurance, health plan, or benefit assignment. Moreover, I understand and acknowledge that Dr. Berlin or Carmel Care PLLC will not bill any third-party payer for any service. All applicable fees are discussed prior to the initiation of treatment. Payment is due in full at the time of service.

MEDICAL RECORDS POLICY ACKNOWLEDGEMENT

Unless specifically prohibited by law, requests for medical records and/or completion of additional forms will incur additional fees. Please be advised that medical records require time to be produced and cannot be provided on the same day.

My signature below indicates my understanding and acceptance of the above statements.

A photocopy, scan, or any other digitized version of this signed original shall be deemed to be, and should be accepted as, an original.

Signature of Patient or Representative: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____