DR. WAYNE LEE

PATIENT/CLIENT NAME: ______________________________

SOCIAL SECURITY: ______________________________

DATE OF BIRTH: ______________________________

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, as patient (or the patient's duly authorized representative) and do hereby voluntarily consent to and authorize medical care encompassing all the diagnostic and therapeutic treatments and transfers to other facilities considered necessary or advisable in the judgment of the attending physician, his/her assistants or designee. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations performed in this facility. I authorize Dr. Wayne Lee or members of his attending staff to retain, preserve and use for scientific purposes, or dispose of at their convenience, any specimens to me and I certify by my signature that I understand and accept its contents, except as noted.

FINANCIAL RESPONSIBILITY STATEMENT

It is the policy of Dr. Wayne Lee to bill your insurance as a courtesy to you, even though you may be considered responsible for the entire bill when services are rendered. If your insurance carrier does not remit payment within 60 days, the applicable balance will then be due in full from you. Unless your insurance company has a contract with Dr. Wayne Lee to pay based on a specific negotiated fee schedule, you may be held responsible for any difference remaining between the insurance payment and total charges.

We also require that arrangements for payments of your estimated share be made today. If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to Dr. Wayne Lee.

However, if you are an HMO enrollee, the above statement only applies to your applicable co-pay and/or any other non-covered charge that you have agreed to be responsible for in advance of treatment. If you are Worker's Compensation patient, you will only be held responsible for charges in the event your claim is controverted (not approved by either your employer or insurance company).

You understand and agree that if you fail to make any of the payments for which you are responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Dr. Wayne Lee, you will be responsible for all cost of collecting monies owed including court costs, collection agency fees and attorney fees. You also understand that you are responsible for keeping Dr. Wayne Lee advised of any address changes. If

any correspondence is returned, you understand that the account will be considered in default and will be turned over for collection immediately.

The above information has been read and your signature on the front side of this form signifies that you understand you are responsible for the payment of your account.

RELEASE OF INFORMATION

I hereby authorize Dr. Wayne Lee to release information to my insurer (s), their agent (s), (including employer, if work related injury), about my injury or disability, medical condition, evaluation, treatment, work history or any other and all medical information as may be necessary for payment of my hospital and medical claims, except as otherwise provided applicable State or Federal Laws. This release also allows information to be released for utilization review and other contained in the medical record pertaining to the medical condition or injury for which I have sought treatment. In addition, this release authorizes Dr. Wayne Lee to release my records to any referred physician for purpose of continued medical care. This will include all pertinent clinical notes, diagnostic tests, and personal information. Also, any medical information returned from the referral physician used for Case Management purposes can be released to the above listed entities. I understand that this authorization any be revoked by me at any time and that it is valid for a period which is consistent with the Medical Records Policy of VPM and its personnel a re hereby released from all legal responsibility for such release of information as described above.

A photocopy of this document shall be considered to be as valid as the original.

BENEFIT ASSIGNMENT

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to Dr. Wayne Lee. A photocopy of this assignment is to be considered as valid as the original.

Your signature below signifies that you have read and acknowledge the policies explained on both sides of this form regarding 1) Release of Information, 2) Benefits Assignment, 3) Consent for Medical Treatment, and 4) the Financial Responsibility Statement.

______________________________ ______________

Patient or Responsible Party Date

______________________________ ______________

Dr. Wayne Lee Representative Date