

George G. Westerman, MD, CPE, FACPE
2625 S. Rainbow Blvd #C-106
Las Vegas, NV 89146
(702) 341-6411

CONSENT FOR TREATMENT
&
CONDITIONS OF TREATMENT

In signing this document I indicate that I understand and agree to the following conditions of treatment:

- ❖ I consent to the treatment for myself (or for the named patient) which Dr. Westerman considers clinically necessary.
- ❖ I accept financial responsibility for all charges incurred for the services provided irrespective of insurance coverage and its possible limitations.
- ❖ Payments are due at the time of service, unless other arrangements have been made in writing.
- ❖ I authorize the release of information necessary to file insurance claims. I assign to Dr. Westerman the benefits payable from any third party who is responsible for payment for his services. Third party payors are authorized and directed to pay all benefits directly to Dr. Westerman.
- ❖ I agree that past due bills may require collection or attorney intervention, and if so, I agree to pay these costs.
- ❖ **I understand that an appointment time will be reserved for me. I agree to be charged and pay fee of \$50.00 if I fail to keep an appointment or I fail to provide 24 hr. notice when canceling an appointment for ANY reason.**
- ❖ I accept the responsibility to inform this office of changes in address, telephone number and insurance coverage.
- ❖ I authorize Dr. Westerman to coordinate my care and communicate with my personal physician except as follows _____.

This agreement can only be revoked in writing by the undersigned.

Patient Signature

Date

Person Responsible for Patient—Signature

Date

Witness

Date