Consent to Treatment and Financial Responsibility

Patient's Name: _____
(First) (Middle) (Last)

I understand, confirm, and acknowledge that I have been informed regarding the following:

1) Any treatment or advice provided to me as a patient of Dr. Anne Jacobs is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future receive from any other health care provider.
2) I am at liberty to seek or continue care with any other physician, surgeon, or other health care provider.
3) Dr. Anne Jacobs does not suggest or recommend to me to refrain from seeking or following the advice of any other licensed health care provider.
4) The treatment and therapies provided by Dr. Anne Jacobs may be different from those offered by another licensed health care provider.

I voluntarily consent to receive health care services from Dr. Anne Jacobs that may include: diagnostic procedures, examination, and treatment.

I understand that I am legally responsible for all charges made in connection with treatment provided to me by Dr. Anne Jacobs.

I agree to pay on the day of service for any fees including: supplements and other remedies, laboratory tests, and doctor's services.

If applicable, Dr. Jacobs may bill insurance on my behalf and release my information if requested.

I agree to a $50 fee for all missed appointments not canceled 24 hours in advance.

E-mail: I understand that of my own accord, I can e-mail with Dr. Jacobs about current treatment plans. I understand that e-mail transmissions may not be completely secure from either my server program or Dr. Anne Jacobs' program. In addition, I am aware that e-mails related to clarifying a current treatment plan, if short in duration and scope, will not be charged. However, if the e-mail pertains to new health concerns or questions, then I will be charged a minimum $25 consult fee or asked to come in for an appointment.
A schedule of fees for treatment by Dr. Anne Jacobs is available at the front desk.

I certify that I have read this form, understand its contents and hereby authorize and consent to treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____
(Patient Signature) (Date)

I would like my primary care or other health care provider to be informed of our treatment plan and ask that Dr. Jacobs send a report of this initial visit.

_____ _____
(Name of Provider and Fax Number) (Patient Signature)