PLATTSBURGH MEDICAL CARE

The undersigned makes the following acknowledgments and agreements regarding treatment to be provided to the patient whose name appears below

1. **Consent to treatment:** I consent to any medical or surgical treatment rendered to the patient under general or special instructions of the physician. I certify that no guarantee of assurance has been made to me as to the results which may be obtained.

2. **Release of medical information:** I authorize the release of any medical or other information from this provider and other providers necessary to process a health insurance claim or to provide treatment.

3. **Assignment of benefits:** I authorize payment of medical benefits to Plattsburgh Medical Care PLLC

I certify that the information given at the time of registration is correct. I understand that I will be financially responsible for all charges in full at the time I am given treatment unless otherwise agreed upon before treatment is rendered. I understand that I am financially responsible to Plattsburgh Medical Care for charges not covered by insurance.

Notice of Privacy Practices Receipt Acknowledgement

I have been presented with a copy of Plattsburgh Medical Care's Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice.

Printed Name:_____ DOB:_____

Signature:_____ Date:_____

EMERGENCY CONTACT INFORMATION

Emergency Contact 1:_____ Relationship:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Emergency Contact 2:_____ Relationship:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

675 Route 3
Plattsburgh, NY 12901
518-566-0672