ANGIER PEDIATRICS AND ADULT MEDICAL CENTER, PLLC

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KINGSLEY C. UGOCHUKWU, M.D.

PLEASE PRESENT ALL OF YOUR INSURANCE CARDS AT THE TIME OF REGISTRATION. I, _____, AUTHORIZE AND CONSENT TO MEDICAL CARE BY ANGIER PEDIATRICS AND ADULT MEDICAL CENTER, PLLC INCLUDING PROCEDURES, DIAGNOSTIC TESTING, AND MEDICAL TREATMENTS AS DEEMED APPROPRIATE IN RELATION WITH THE MEDICAL PROBLEMS IN WHICH I HAVE SOLICITED CARE FROM THIS FACILITY. I AUTHORIZE ANGIER PEDIATRICS AND ADULT MEDICAL CENTER, PLLC TO COMMUNICATE MY MEDICAL INFORMATION WITH MY INSURANCE COMPANY AS NEEDED FOR REIMBURSEMENT FOR SERVICES. I UNDERSTAND THAT I, THE PATIENT, WILL BE RESPONSIBLE FOR ANY COSTS NOT COVERED BY MY INSURANCE.

POR FAVOR PRESENTE TODAS SUS TARJETAS DE SEGURO MEDICO AL REGISTRO. YO, _____, AUTORIZO Y ESTOY CONCIENTE AL CUIDADO MEDICO INCLUYENDO PROCEDIMIENTOS DIAGNOSTICOS, Y TRATAMIENTOS COMO SEAN APROPIADO EN RELACION DE MIS PROBLEMAS MEDICOS POR LO QUE HE SOLICITADO SERVICIOS MEDICOS DE ANGIER PEDIATRICS AND ADULT MEDICAL CENTER, PLLC. YO AUTORIZO ANGIER PEDIATRICS AND ADULT MEDICAL CENTER, PLLC QUE COMUNIQUE INFORMACION MEDICA SOBRE MI A LAS COMPANIAS DEL SEGURO MEDICO COMO SEA APROPIADO. YO EL PACIENTE TENGO ENTENDIDO QUE YO SERE RESPONSIBLE POR LOS GASTOS QUE NO PAGARA MI SEGURO MEDICO.

SIGNATURE OF PATIENT: _____ DATE: _____

FIRMA DEL PACIENTE: _____ FECHA: _____