



**AUTHORIZATION TO TREAT AND
ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY**

I, the undersigned, authorize the Lakes Urgent Care, P.C. to perform medical and/or minor surgical procedures, which may be recommended by the physician or physician assistant rendering care to:

Patient's Name

I, the undersigned, accept full financial responsibility for any portion of the bill for services that my insurance carrier(s) does not pay.

Signature

Relationship to Patient

Date

Witness: _____

Date