1900 E. Desert Inn Road, Las Vegas, NV 89169
contact@desertinnmedicalclinic.com
(702) 425-6125
(702) 208-2202

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent to Desert Inn Medical Clinic to furnish any medical care and treatment to myself/child that is considered necessary and proper in diagnosing or treating his/her physical condition.

INITIAL ____________

FINANCIAL POLICY STATEMENT

We bill your insurance solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require the payment of your estimated share be made at the time of service. If your insurance carrier does not remit payment within 80 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payment made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

INITIAL ____________

Your insurance company requires Desert Inn Medical Clinic to collect your co-payment/deductible at the time of service or, we could be in violation of our contract and risk not being reimbursed for your treatment process. Our office staff can collect payment from you with a credit/debit card or cash. **AS A COURTESY WE WILL BILL YOUR INSURANCE COMPANY FOR THEIR PORTION OF THE BILL.** If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to Desert Inn Medical Clinic.

INITIAL ____________

CANCELLATIONS AND NO SHOWS

If you are unable to keep a scheduled appointment, please notify us at 24 hours in advance. We will reschedule your appointment. If you fail to keep appointments without notifying Desert Inn Medical Clinic in advance, the physician reserves the right to charge a $50 fee for the unused appointment time.

INITIAL ____________

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to Desert Inn Medical Clinic. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical-records, to secure payment. By signing this form, I understand my financial responsibilities as a patient

INITIAL ____________

____________________________   ___/___/___

Parent/Legal Guardian Name & Signature   Date: