CONSENT TO TREATMENT

I, the undersigned, do hereby consent to any diagnostic procedures, including X-ray examination, blood tests, medical care and treatment, hospital service that may be rendered to me or my dependent, under the general or specific instructions of Doctor Loanne Tran, M.D., licensed to practice in the State of California. Such diagnosis and treatment may be rendered at the doctor's office or at the hospital licensed by the State of California.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given in order that said physician may have the opportunity to exercise her best judgment as to the action which may be necessary or required to protect my or my dependent's life and health.

This consent shall remain in effect until revoked in writing delivered to the physician or her representative.

I authorize the above named physician to release any information regarding my health care or my dependent's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize my insurance carrier to pay benefits directly to the physician for services rendered to me or to my covered dependents. I understand that I am financially responsible to the named physician for charges not covered and not paid by my insurance carrier.

Signature of Patient:

Date:

First Name **Middle Name / MI** **Last Name**

Signature of Parent/Guardian: (If patient is a minor)

Parent/Guardian Name:

First Name **Last Name**

Date:

Please note: We will charge a fee of $25.00 for a missed appointment if not cancelled 24-hour in advance.