LONG BEACH INTERNAL MEDICAL GROUP INC.

Patient Registration II

AUTHORIZATION TO TREAT

I (and/or the undersigned on behalf of the patient) voluntarily consent to allow Long Beach Internal Medical Group physicians and staff to provide such evaluation and/or care and treatments as an outpatient on a continuing basis and as an inpatient as necessary, as Long Beach Internal Medical Group physicians and staff may decide is advisable and necessary.

I understand that although care is reviewed and supervised by Long Beach Internal Medical Group physicians, actual care may be rendered by physician extenders (i.e. physician assistants, nurse practitioners).

I am advised that such treatment may include physical examination, x-ray examination, laboratory procedures, other office procedures as well as inpatient procedures as required.

I understand that should I execute a Durable Power of Attorney for Health Care or other Advance Directive, I will provide an executed copy to my physician. I further understand that I will notify my physician of any changes in the Directive.

I understand that I will be informed about the course of my treatment. Also, I am free to terminate my treatment with my Long Beach Internal Medical Group physician at any time.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges, whether or not paid by my insurance, unless specifically exempted by my insurance company's contract with Long Beach Internal Medical Group.

ASSIGNMENT OF BENEFITS

I hereby assign medical and/or surgical benefits, private insurance, and any other health plan benefits to Long Beach Internal Medical Group. A copy of this assignment is considered valid as the original.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Long Beach Internal Medical Group to release any medical information necessary to my insurance company or its agents in order to secure payments.

I certify that I have read the foregoing and have received a copy of it. As the patient, the patient's guardian, conservator or general agent, I agree to accept the above terms.

_____ _____
Patient's Signature Date

_____ _____ _____
Interpreter (if applicable) Patient's Guardian/Conservator or Date
See note of_____ General Agent
date

_____ _____
Relationship to Patient/Minor Date

_____ _____
Witness Date

***Special release needed for HIV test results, psychiatric & chemical/alcohol treatment record**