Consent to Treatment
Cameron S. Schaeffer, MD, PSC

I voluntarily authorize Cameron S. Schaeffer, MD, PSC and/or its agents to provide medical and surgical care for me or for the person for who I am a legal guardian or custodian. This includes medical and surgical care, as well as any necessary testing. I acknowledge that no guarantees have been made as to the effect of such examination and treatment on my condition or on the condition of the person for whom I am duly authorized to sign. I understand that I have the right to make the decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse recommended medical or surgical care.

I understand that my medical record or the medical record of the person for whom I am duly authorized to sign as confidential. This information will be maintained by Cameron S. Schaeffer, MD, PSC and its agents, Abacus, Inc., a billing and data management company. I understand that no information will be released from this record except as noted below. I authorize the release from my medical records or from the records of the person for whom I am duly authorized to so, of any medical or psychiatric information as may be required by:

Any health or accident insurance carrier, workman's compensation, or agency which is legally responsible (social, welfare, governmental), or which Cameron S. Schaeffer, MD, PSC has good cause to believe is legally responsible for all or any part of its professional fees.
Any physicians or health care facilities rendering professional care to the patient.
Any Peer Preview Organization responsible for reviewing medical care.

I authorize Cameron S. Schaeffer, MD, PSC to obtain medical records form other physicians, hospitals, or health care facilities that it deems necessary for my medical care or for the care of the person whom I am duly authorized to sign. This consent will remain in effect until Cameron S. Schaeffer, MD, PSC is otherwise notified by me in writing.

I agree to be responsible to Cameron S. Schaeffer, MD, PSC for charges resulting from care rendered by Dr. Schaeffer and his agents not covered by my insurance, if any. All bills are due in full on demand. If I fail to honor this agreement, I agree to pay any collection cost or attorney fees resulting from the collection of my accounts. I agree that Cameron S. Schaeffer, MD, PSC is not party to any disputed claim or peer-review decision which affects payment of any claim filed on my behalf, and that upon my request for payment by Cameron S. Schaeffer, MD, PSC, I agree to pay any outstanding balance.

I hereby assign all rights and privileges and authorize payment directly to Cameron S. Schaeffer, MD, PSC for any claim filed on my behalf or on the behalf for any of the person for whom I am duly authorized to sign for insurance benefits. I agree that I am financially responsible to Cameron S. Schaeffer, MD, PSC for charges not covered by this assignment or not paid on a timely basis by the insurance company.

I certify that I have read and understand the authorizations given above and I am the patient, or the person duly authorized by the patient to execute the above and accept its terms.

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Patient Parent or Legal Guardian