Joseph S. Weiner, MD, PC
Registration Form

Last Name: _____ First Name: _____ M.I._____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Date of Birth: / /

Social Security Number: _____

General Consent for Treatment

I hereby consent to and authorize Joseph S. Weiner, MD, PC (hereinafter, "Dr. Weiner") to evaluate my medical condition and conduct any routine and non-invasive diagnostic and therapeutic procedures and treatments (excluding all invasive procedures and/or procedures that bear risk to life or health), which in Dr. Weiner's judgment are necessary for my care. I understand that I have a right to refuse any recommended treatment once it has been explained to me.

Date: _____ Signature: _____

Consent for Release of Information to Insurance Companies and Third Party Payors

I hereby authorize and direct Dr. Weiner to release to his billing service and to governmental agencies, insurance carriers and/or others who are financially liable for my medical care, all information needed to substantiate payment for such care and to permit representatives thereof to examine and make copies of all records relating to such treatment to the extent necessary to process claims.

Date: _____ Signature: _____

Financial Responsibility/Guarantee of Payment

For, and in consideration of, services rendered to be rendered by Dr. Weiner, I hereby guarantee full payment of any bills for such services, or if Dr. Weiner accepts Assignment of Benefits, any bills for such services that are not covered or allowed by the governmental agencies or insurance carriers financially liable for such services.

Date: _____ Signature: _____