

2935 Baseline Road; Suite 201; Boulder, CO 80303
Phone: (303) 444-3152 Fax: (303) 444.3151

CONSENT TO TREAT

I _____ voluntarily consent to receive any
(Printed Patient Name)
medical and health care service at Mountain View Dermatology offered by Dr.
Richard Levine and his staff; including diagnostic procedures, examinations and
treatments.

FINANCIAL INFORMATION AND ASSIGNMENT OF BENEFITS

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS (CO-
PAY, REFERRAL, DEDUCTIBLE AND COVERAGE). YOUR INSURANCE PLAN
IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. IT IS
IMPOSSIBLE FOR OUR OFFICE TO BE FAMILIAR WITH ALL INSURANCE
PLANS. IF YOU HAVE QUESTIONS PLEASE CONSULT YOUR INSURANCE
COMPANY DIRECTLY.

**I agree to pay all charges for medical and health care services not covered by my
insurance company.**

I certify that I have read this form and understand its contents.

Signature of Patient (or other Legally Authorized Person)

Date