

**PATIENT'S ACCEPTANCE OF CONDITIONS
AND RELEASES**

I hereby authorize the release of any medical information acquired in the course of my treatment, to designated physicians and related professionals, and/or insurance companies as necessary to provide medical care and to process any medical claims.

I accept responsibility for notifying Dr. Rollins or his office staff if my insurance requires pre-authorization for any benefits, restricts the use of certain laboratories or therapy facilities, limits referrals to other doctors, or otherwise obstructs my medical care.

I agree to notify this office immediately if my insurance coverage changes or is terminated.

If a written referral from a primary doctor is required prior to a visit, (eg. HMO, IPA or Managed Care), I acknowledge that it is my responsibility to insure that this referral has been obtained. I will pay for any charges denied by an insurance carrier because of lack of such referral.

I hereby assign medical benefits/payments from my insurance company directly to John S. Rollins, M.D.

I realize that I will receive a monthly statement (account summary) whenever my account has a balance (workers' comp. accounts excluded). I agree to assist Dr. Rollins' office staff as necessary to insure prompt payment by my insurance company. I also agree to promptly pay all amounts due by me as specified by my insurance company and noted on any statement received from Dr. Rollins and/or my insurance company.

SIGNATURE

DATE

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