Patient's Name ____ Date of Birth ______________________

CONSENT FOR TREATMENT: I consent to evaluation and medically necessary treatment by Taliba M. Foster M.D. No guarantee is being made to me about the results of treatment. I can terminate this consent for treatment at any time.

AGREEMENT TO PAY: I agree to pay Taliba M. Foster M.D., all charges for professional services. I agree to pay for appointments cancelled without a 24-hour notice. I also agree to pay for depositions, court appearances, and contact with attorneys related to divorce, custody, visitation, involuntary commitment, social security benefits, disability benefits, and workman's comp issues involving above patient in any way. I will be personally responsible for these charges even if my medical insurance company does not pay. I agree to pay for charges related to record retrieval, copying costs, and statement of opinion when I authorize release of my records to any outside party. In the event of default I promise to pay such collection costs and attorney fees as may be required to effect collection of the indebtedness.

PRIVACY PRACTICES: I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

PHOTOCOPIES: I hereby authorize photocopies and electronic copies of this form to be as valid as the original.

The invalidity of any provision of this agreement will not affect the validity of any other provision.

I have read this agreement carefully before signing.

____________________________	______________	____________________________________
Signature of Patient	Date	Witness

____	________________________________
Signature of Insured/Guarantor/Authorized Representative (If different from above)	Signature of Legal Guardian