

**Diabetes, Thyroid and Endocrinology of Northern Ohio**

**Consent Form**

I consent to treatment by Dr. Vikram Kumar and/or such physicians and assistants as may be selected by him to diagnose and treat the condition or conditions from which I am suffering by such means including diagnostic exam/testing and in-office procedures, as he believes indicated by his studies of my case.

I authorize Diabetes, Thyroid and Endocrinology of Northern Ohio to submit and all health care information, which may include drug and alcohol history and HIV status to my health insurance program for their review and payment. I understand that it is my responsibility to know the benefits of my insurance plan. I also understand some services, test or consultations may not be covered by my insurance plan and that I am financially responsible for any services that are not covered by my benefit plan, including denials for failure to obtain prior authorization or referral.

I understand that co-payments are due at the time of service.

By signing below, I am also verifying that I have legal authority to authorize medical treatment, as well as authorize payment to be made to Diabetes, Thyroid and Endocrinology by my insurance carrier

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Patient's Name

\_\_\_\_\_  
Witness