Moorpark Family Medicine

Jonathan Rosaasen M.D. & Amanda Rosaasen M.D.
301 Science Drive Suite 190
Moorpark, CA 93021

Phone (805) 531-9400 Fax (805) 531-9499

www.moorparkfm.com
moorparkfm@gmail.com

AUTHORIZATION FOR MEDICAL TREATMENT

I, ____________________ (Patient name) hereby authorize Moorpark Family Medicine, Inc., associates and assistants as designated by Drs. Jonathan or Amanda Rosaasen to perform evaluation and treatment of my medical condition. I further require and authorize Moorpark Family Medicine, Inc., associates and assistants, to perform additional procedures, as they may deem immediately necessary on an emergent basis. I understand that elective minor surgical procedures will be consented separately.

I consent to the administration of medications and injections (also consented separately) deemed necessary in the judgment of Moorpark Family Medicine, Inc., associates and assistants as designated by Drs. Jonathan or Amanda Rosaasen.

Moorpark Family Medicine, Inc. can release to my insurance company any medical information necessary to process my insurance claim. I hereby assign benefits from my insurance company to be payable directly to Moorpark Family Medicine, Inc.

I recognize that the practice of medicine is not an exact science, and Moorpark Family Medicine, Inc. does not guarantee the results of treatment.

Signed: ________________________________ Date: ______________________
Printed Name: ____________________________ Telephone: _________________

If not signed by the patient, please indicate:

Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: ________________________________ Date: ______________________
Printed Name: ____________________________ Telephone: _________________

If not signed by the patient, please indicate:

Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: ____