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Consent for Treatment

I desire to be seen and treated at Midtown Medical Clinic, and hereby give my consent for the clinics, its physicians, employees, and contractors to see and treat me as they deem necessary and appropriate for diagnosis and treatment. I authorize and consent to examinations, x-rays, blood tests, including blood tests for communicable diseases such as Hepatitis and AIDS, (and including testing where healthcare personnel have been exposed to my blood and/or body fluids), laboratory procedures, medication, infusions, transfusions of blood, anesthesia, radiation therapy, and other services, treatments rendered or performed at Midtown Medical Clinic and or such persons to report certain positive test results, such as, but not limited to Hepatitis and the antibody for the AIDS virus to the health department.

I understand that I have the right to ask questions and to receive information regarding my care and treatment and the right to withdraw, in writing, my consent to treat or test.

I understand that I am financially responsible for payment of all services rendered to my family or me. Although Midtown Medical Clinic will bill or arrange for billing to my insurance carrier, I understand and agree that I am responsible for payment of all charges for services provided regardless of the availability of an insurance coverage(s). I agree to pay all co-payments and deductibles. In the event that I fail to pay any charges and the account is turned over to a collection agency or an attorney, I agree to pay all collection costs incurred, but not limited to reasonable attorney fees and court costs.

I agree that if I refuse treatment recommended by Midtown Medical Clinic, its physicians or employees, or if I leave the clinic against the advice of such physicians(s) or Midtown Medical Clinic personnel, then the clinic, its physicians, employees, and all other persons are released from any responsibility or liability for any injuries or damages which may result from my refusal of treatment or my acting against such advice.

I hereby authorize the release of any and all medical information requested by or otherwise necessary to process my claims with my insurance company, the Social Security Administration and its intermediaries, Medicare, Medicaid, or any other organizations responsible for payment, charges for or related to any services provided to me or my family. I hereby assign and authorize payment to Midtown Medical Clinic or any insurance, managed care, or other benefits that are filed by Midtown Medical Clinic for services provided for me or my family.

I hereby authorize and request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Midtown Medical Clinic for any services furnished to me.

I have read and agree to the HIPPA privacy practices in this office.

Signature: _____ Date: _____

Witness: _____