

**H. T. Treadwell, III, CRNA
And
R. Kent Cannaday, CRNA**

**CONSENT AND DISCLOSURE
PLEASE READ BEFORE YOU SIGN**

Patient Name: _____ Date: _____

Authorization to Release Information: I hereby authorize the physician or its designated representative to release information concerning examination, testing, and treatment of the above patient to any insurance company, attorney, other medical facility, or other physicians requesting the said for purposes of determining eligibility for payment of insurance.

Authorization to Obtain Information: I hereby authorize, **H.T. Treadwell, III, CRNA and/or R. Kent Cannaday, CRNA, to obtain information concerning examination, testing, and treatment of the patient form any insurance company, attorney, other medical facilities, or physician.**

Statement of Financial Responsibility: The undersigned agrees whether he/she signed as agent or a patient, that in consideration of services to be rendered to the patient, he/she individually obligated himself to pay the account in accordance with the regular rate charge by the provider. Should the account be referred to collections, whether it is a collection agency or attorney, the undersigned agrees to pay the collection expense and reasonable attorney fees equal to 32% of the outstanding payable due. Should protracted litigation result, the court may set an attorney fee in excess of 32% of the outstanding balance.

Consent for Treatment: The undersigned hereby consents to examination and treatment of the patient by the physician, and to his or her designee, and to the performance of any surgical or diagnostic procedure, which the physician treating the patient deems necessary under the circumstances.

Authorization to Pay Insurance Benefits and Guarantee of Payment: I authorize payment to, **H.T. Treadwell, III, CRNA or R. Kent Cannaday, CRNA, of any benefits specified and otherwise payable to me, but not to exceed the reasonable and customary charges. I understand I am financially responsible to these providers for charges not covered by the assignment. I understand that charges no payable by Insurance are my responsibility. All charges are due in full within 90 days from the date of surgery regardless of any insurance pending.**

Statement to Permit Payment of Medical Insurance Benefits to Physicians: I certify that the information given by me in applying for payment under titles V, XVII, and XIX of the Social Security Act is complete and correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its carrier any information needed for this or any related Medicare/Medicaid Claim. I request that payment of authorized benefits be made on my behalf to:

H.T. Treadwell, III, CRNA or R. Kent Cannaday, CRNA. I hereby authorize the physician or it's designated representative to obtain, from the Social Security Administration, and the agency, to release any information to establish my entitlement to Medicare/Medicaid benefits.

Patient Signature: _____ Date: _____

Patient's Agent/Guarantor (relationship): _____

Witness: _____