



**CONSENT TO TREAT, ASSIGNMENT OF BENEFITS, AND RELEASE OF INFORMATION TO INSURANCE COMPANIES**

***Please initial each box***

( \_\_\_\_\_ ) I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE PATIENT INDICATED ON THIS FORM. I UNDERSTAND THIS FACILITY MAY EMPLOY PHYSICIAN EXTENDERS.

( \_\_\_\_\_ ) I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE ATTENDING PHYSICIAN FOR SERVICES RENDERED. AUTHORIZATION IS HEREBY GRANTED TO RELEASE INFORMATION AS MAY BE NECESSARY TO PROCESS AND COMPLETE MY CLAIM. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_