

GEORGE P. CHATSON, M.D.

Patient Name _____ Date _____

AUTHORIZATIONS

Please initial all applicable authorizations and sign below:

TREATMENT CONSENT I hereby give permission to George P. Chatson, M.D. to administer treatment and perform such general procedures as he may deem necessary for the diagnosis and/or treatment of my condition.

Initial _____

CONSENT TO BE PHOTOGRAPHED In connection with the medical services which I am receiving from George P. Chatson, M.D. I consent that photographs may be taken of me or parts of my body, under the following conditions: The photographs shall be taken by Dr. Chatson or by a competent photographer, approved by George P. Chatson, M.D. These photographs shall be used for insurance purposes and/or medical records only, unless in the judgment of my physician, medical research, education or science would benefit in their use; in that event, I allow that they may be used for scientific and teaching purposes with the understanding that my name shall be omitted in the use of the photographs. *Initial* _____

ASSIGNMENT OF BENEFITS I hereby authorize assignment of payments directly to George P. Chatson, M.D. for any surgical and/or medical benefits, which are payable to me for this service described above. I understand that I am financially responsible for the charges not covered by this assignment of benefits or my insurance. I hereby authorize George P. Chatson, M.D. to release any information relative to medical care received by me for purposes of treatment and/or payment. *Initial* _____

INSURANCE WAIVER It is the patient's responsibility to know their insurance guidelines and follow protocol for securing a valid referral, according to your plan's guidelines. I acknowledge that if a valid referral is not obtained, I agree to pay and all fees associated with my office appointment and/or surgery should my insurance company deny coverage. *Initial* _____

HEALTH DISCLOSURE/NOTICE OF PRIVACY PRACTICES I consent to the use or disclosure of my protected health information by or to George P. Chatson, M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of George P. Chatson, M.D. I acknowledge having received a copy of the practice's Notice of Privacy Practices.

Initial _____

Signature of patient

Date

Signature of parent/guardian (if applicable)

Print name of parent/guardian