Authorization and Consent to Treat

<u>AUTHORIZATION OF ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION AND CONSENT FOR TREATMENT:</u>

I hereby authorize payment directly to Paris Lakes Health Group for services rendered and supplies provided by Paris Lakes Health Group. I understand that this assignment is for all benefits otherwise payable to me, but not to exceed my indebtedness to said Clinic. I authorize Paris Lakes Health Group to release any information acquired in the course of treatment or examination. I understand that I am financially responsible to Paris Lakes Health Group for charges not covered by this assignment. I authorize the release of any and all medical information necessary to process these claims and I request payment of any benefits due me or for my benefit to be made directly to Paris Lakes Health Group.

I hereby authorize and consent to be treated by Paris Lakes Health Group physicians and staff. The undersigned consents to any X-Ray, examination, laboratory procedures, anesthesia, minor surgical procedures or any medical services rendered under the general or specific instructions of the Paris Lakes Health Group physicians. The undersigned recognizes that some persons furnishing professional medical services, including but not limited to radiology and pathology, may independent contractors and not employees or agents of the Clinic.

<u>AGE OF CONSENT—WHERE MINORS ARE INVOLVED, THE FOLLOWING SHALL PREVAIL:</u>

1) The consent of parent or legal guardian if patient is unmarried and has not yet attained the age of (18).

2) If a patient under (18) years of age is married, or has been married and such marriage has been dissolved by dissolution or annulment, then the consent of a parent or legal guardian is not required.

The undersigned hereby acknowledges that he or she has read and fully understands the foregoing, and has voluntarily executed this document. The undersigned further acknowledges that he or she is the patient, or is duly authorized by and on behalf of the patient to execute this document, and accepts its terms personally and upon the patient’s behalf. The release of information set forth herein above is valid, and the assignment of benefits and financial agreement is valid and binding until final settlement of the account is received.

SIGNATURE________________________DATE_______________________