DR. PAULA D. MOORE
DYSAUTONOMIA-MVP CENTER

PATIENT LEGAL NAME: _____
DATE OF BIRTH: _____/_____/_____

CONSENT FOR TREATMENT

CONSENT FOR TREATMENT – I consent to necessary treatment, including: drugs, medicine, performance of operations and conduct of x-ray, or other studies that may be used by the attending physician, her nurse or staff. I further authorize this clinic to access any medical history related to my care.

AUTHORIZATION FOR RELEASE OF INFORMATION – I authorize Dysautonomia-MVP Center to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

ASSIGNMENT OF BENEFITS – I hereby authorize payment directly to Dysautonomia-MVP Center of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the Dysautonomia-MVP Center charges for these services. I understand that I am financially responsible to Dysautonomia-MVP Center charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT – For services furnished by Dysautonomia-MVP Center, I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collections, including attorney's fee.

***** Please note that this document is required by law to be updated annually, so only sign once *****

PATIENT'S SIGNATURE: DATE:

PATIENT'S SIGNATURE: DATE:

PATIENT'S SIGNATURE: DATE:

PATIENT'S SIGNATURE: DATE:

PATIENT'S SIGNATURE: DATE: