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WEST TENNESSEE MEDICAL GROUP CLINICS

Patient Authorization:

1. I consent to treatment necessary for the care of the below named patient.
2. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
3. I allow fax transmittal of my medical records, if necessary.
4. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
5. In the event the charges incurred are not paid-in-full when due and collection action is instituted whether by collection agency, or attorney, or both; I agree to be responsible for and to pay in addition to the charges for services and treatment received all costs associated with such collection activity including, but not limited to, reasonable collection agency fees, attorneys fees, and court costs.
6. I further authorize and request that insurance payments be made directly to the provider.
7. I have read and fully understand the above consent for treatment and financial responsibility, release of medical information, and insurance authorization.
8. I agree with all the above with the exception of number _____.
9. I acknowledge full financial responsibility for services rendered by West Tennessee Medical Group at any of their locations.

_____ _____ _____ _____

Patient (or Guardian) Signature Date Witness Date

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this document, I acknowledge that I have received a copy of The Clinic's Joint Notice of Privacy Practices.

_____ _____ _____

Name (Print) Signature (Relation, if other than patient) Date

☐ Patient unable to sign/ No family available

☐ Patient refused to sign

☐ Other:

_____

☐ Employee

Signature:_____

The Clinic's Use Only (Do not write below this line)

Date acknowledgment mailed: _____

Date acknowledgment received: _____

Advanced Directives:

Do you have a living will or durable power of attorney? ☐ No ☐ Yes

If you do have a durable power of attorney, please identify:

_____

Would you like us to give you a packet of information regarding advance directives:

☐ No ☐ Yes (Packet distributed)

_____ _____ _____ _____

Patient Signature Date Witness Date