CENTER FOR Breast Health & IMAGING

Consent to Treat Form

102 DOCTORS PARK, STARKVILLE MS 39759 PHONE (662)615-3800 FAX (662)615-3807

CONSENT TO TREAT

I hearby authorize Charles Wall, M.D., Travis Methvin, DO or Dana Brooks, FNP-C, to administer treatment and medications as may be deemed medically necessary and advisable.

AUTHRORIZE TO RELEASE INFORMATION

I hearby authorize Charles Wall, Jr, M.D., Travis Methvin, DO or Dana Brooks, FNP-C, or any holder of medical information about me to release to the Health Care Financing Administration and its agents (Medicare), Insurance Companies or Third Parties, any information needed to determine these benefits payable for the related services.

ASSIGNMENT OF BENEFITS

I request that authorized Medicare or Insurance payments of medical benefits be made to Charles Wall, M.D, Travis Methvin, DO or Dana Brooks, FNP-C.

GUARANTOR RESPONSIBILITY

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Charles Wall, M.D., Travis Methvin, DO or Dana Brooks, FNP-C (Center for Breast Health and Imaging is affiliated with OCH Regional Medical Center,) and if this assignment is rejected, modified or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel and court.

This authorization and assignment may be revoked by me, at any time by written notice.

I agree that a photocopy of this form may be used in lieu of the original.

_____ _____ _____

Signature of Responsible Party **Date** **Time**

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REVISION/REVIEW HISTORY

Author	Revision Date	Page #	Summary of Changes
Tawana Gipson	8/23/16	1	Header and Footer added
Cheryl Smith	07/20/17	1	Added Dr Wall as physician and changed spacing to fit
Cheryl Smith	04/04/19	1	Changed street address