MEDICAL ASSOCIATES

107 BRANDON ROAD, STARKVILLE MS 39759 PHONE (662)615-3771, FAX (662)615-3775

CONSENT TO TREAT

I hereby authorize Joshua T. Black, M.D., Mercedes Terrell, M.D., Ben Sanford, M.D., Audrey Schilling, N.P., or Connie Wilson, N.P., to administer treatment and medications as may be deemed medically necessary and advisable.

AUTHRORIZATION TO RELEASE INFORMATION

I hereby authorize Joshua T. Black, M.D., Mercedes Terrell, M.D., Ben Sanford, M.D., Audrey Schilling, N.P., Connie Wilson, N.P., 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 Joshua T. Black, M.D., Mercedes Terrell, M.D., Dr. Ben Sanford, M.D., Audrey Schilling, N.P., Connie Wilson, N.P., or OCH Medical Associates.

GUARANTOR RESPONSIBILITY

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Joshua T. Black, M.D., Mercedes Terrell, M.D., Ben Sanford, M.D., Audrey Schilling, N.P., or Connie Wilson, N.P., (OCH Medical Associates 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**