MEDINA FAMILY MEDICAL CLINIC
209 GRACE COVE
MEDINA TN 38355

Phone: (731) 783-0400 **Fax: (731) 783-0402**

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CONSENT TO TREAT / FINANCIAL RESPONSIBILITY / ADVANCE DIRECTIVE

Name of Patient: _____ DOB: _____ SS# _____

1. I consent to treatment necessary for the care of the above named patient.
2. I authorize the release of all medical records to my insurance company, if applicable.
3. I authorize the release of all medical records to referring and/or family physicians, if applicable.
4. I allow fax transmittal of my medical records, as necessary.
5. I understand that payment of copays, deductibles, coinsurance and charges incurred are due at the time of service.
6. In the event the charges incurred are not paid in full when services are provided and collection action is instituted by a collection agency, or attorney, or both; I understand and agree to be responsible for the outstanding balance and any additional charges incurred due to the collection process. Costs for the collection process include, but are not limited to, reasonable collection agency fees, attorney fees and court costs.
7. I authorize insurance payments be made directly to the provider at Medina Family Medical Clinic.
8. I have read and fully understand the above consent for treatment, financial responsibility and release of medical information.
9. I agree with all the above, with the exception of number: _____
10. I acknowledge full financial responsibility for services rendered by Medina Family Medical Clinic.

_____ _____

Patient or Guardian Signature Date

ADVANCE DIRECTIVES:

1. Do you have a living will, advance directive or durable power of attorney? ☐ YES ☐ NO
2. If you do have a living will, advance directive or power of attorney, please identify location:

_____ _____

Name / Location Phone Number

3. Would you like a packet of information on advance directives? ☐ YES ☐ NO

_____ _____

Patient or Guardian Signature Date

_____ _____

MFMC Witness Signature Date