Conditions of treatment by: Dr. Jack A. Davidson

Permission of treatment: permission is hereby granted for Dr. Jack A. Davidson (collectively, the "Provider") to render the patient named below such medical and surgical treatment as is deemed necessary.

Authorization for release of information: the provider may disclose the patient's medical record and account to:

1. A corporation which is or may be liable for all or any portion of the payment's charges, including but not limited to insurance companies and health care services plans to the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement.
2. Any referring physician to ensure continuity of medical care.

Please initial as applicable:

_____ **Assignment of Insurance Benefits:** I request my insurance carrier to pay to Dr. Jack A. Davidson all benefits due me related to my pending claim and surgical services. I agree to pay all applicable deductibles and coinsurance amounts due and other fees for services rendered for which my insurance plan/HMO is not liable for payment to the provider, and agree to pay the cost of collection including reasonable attorney's fees in the event of legal action to collect such amounts.

_____ **Self-Paying Patient:** I have been informed that Dr. Jack A. Davidson does not have a contract to participate with my insurance plan.
I am requesting medical services as a fee-for-service, self-paying patient.
I agree that I am responsible for all charges incurred as a result of this visit, including but not limited to all medical/surgical professional services and radiological. I agree to pay the cost of collection including reasonable attorney's fees in the event of legal action to collect this amount.

***Cancellation Policy** will be explained by a member of our staff at the time of signing the financial agreement.

_____ _____
Patient's Name (Print) **Date**

_____ _____
Financially Responsible Party's Signature **Date**

_____ _____
Witness' Signature **Date**

Revised: 9/08