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E. Wade Walker, M.D. • JoDon Garringer, M.D. • B. Jamison White, D.O.
L. Michelle Seawright, D.O. • Austin Darbyshire, FNP

Read and initial all statements below

Consent to Treat

_____I authorize and consent to such to such care, examinations, and treatments including but not limited to any medical care, treatment, examinations, diagnostic procedures, and furnishing of supplies as determined necessary by my provider.

Financial Agreement

_____I assume responsibility for all charges incurred for professional services rendered by Hartwell Family Practice providers. I agree to pay my account at the time of service is rendered or will make financial arrangements satisfactory to the above-mentioned medical practice.

_____ I assume responsibility for all monthly finance charges of $3 for all unpaid balance on my account.

_____ I understand that I am responsible for paying $25 for any appointments I did not attend and did not cancel prior to the appointment time.

_____ I understand that I may be subject to a $25 cancellation fee for canceling my appointment within 24 hours of my scheduled appointment time.

Authorization to Release Medical Information

_____ I authorize my provider and their representatives to release and medical information, protect health information pertaining to current treatment, including AIDS Confidential Information and psychiatric information that may be requested by any provider, hospital, healthcare facility for the sole purpose of continuation of care.

_____ I authorize my provider and their representatives to release and medical information, protect health information pertaining to current treatment, including AIDS Confidential Information and psychiatric information that may be requested by any provider, hospital, healthcare facility for the sole purpose of claim payment.

Notice of Privacy Practices

_____ I acknowledge that I have received the Notice of Privacy Practices of Hartwell Family Practice, PC.

_____ _____

Patient Signature **Date**