TECHE ACTION BOARD, INC.
1115 Weber Street
Franklin, LA 70538

# CONSENT FOR TREATMENT AND AUTHORIZATIONS

I, _____,hereby agree and give consent to undergo tests, treatment and other procedures required in the course of study, diagnosis, and treatment of illness under the care of the physician, his/her associates, partners, assistants and designees. I am aware that the practice of medicine and dentistry are not exact sciences and further that no guarantee has been or can be made by the clinic as to the results of the examination or treatment.

**Insurance Information:**

I grant permission to authorized personnel of Teche Action Board, Inc. to release medical and/or dental supporting documentation to my insurance company for services rendered to myself and/or covered dependents.

I agree that all insurance payments for covered services are payable to Teche Action Board, Inc. and not to exceed charges for the services rendered.

I agree that I am responsible for all services not paid by my insurance company. If I receive payments for any services, I agree to reimburse Teche Action Board, Inc.

I understand that there may be additional costs for supplies and equipment related to, but not included in the co-pay, deductible or nominal fee collected at time of service. I understand that I may receive a bill for such additional costs, in accordance with Teche Action Clinic's fee policy, that it is my obligation to pay such bills and that payment arrangements can be scheduled for any unpaid balance. _____

**Motor Vehicle Accident and Worker's Compensation:**

I understand that I am responsible for 100% of the bill for treatment received for a motor vehicle accident or worker's compensation incident, and that I must pay the bill in full on the day treatment is rendered. I also understand that I may not have to pay for treatment rendered if a written document is provided by my lawyer or claim adjustor (representing a workmen compensation or motor vehicle accident case) promising to pay the account in full.

I agree that this consent form will be valid for one year for medical and/or dental services provided to me. I agree that a photocopy of this form may be used in lieu of the original.

| _____ | _____ | _____ |
|---|---|---|
| Patient Signature | Date | Employee Signature |
| _____ | _____ | |
| Parent/Legal Guardian | Date | |