

I consent to treatment necessary for the care of the above named patient or myself.

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

I allow fax transmittal of my medical records, if necessary.

I acknowledge full financial responsibility for all services rendered by Dr. Teresa Denney and her staff, and authorize transfer of all unpaid amounts to my Visa/MasterCard after 120 days from the date of service for any dollar amount owed on my account.

I understand that co- payments for charges incurred are due at the time of service unless other definite financial arrangements have been made prior to treatment.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Date

Signature