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GENERAL CONSENT TO TREATMENT

I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her designees and assistants participating in my care.

I also assign and authorize payment from my insurance company to the physician at Oakland Colon & Rectal Associates, P.C., for any and all services rendered. I agree to pay any charges not covered by my insurance company, or pay in full if I have no insurance coverage.

I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw my consent at any time. I also understand that co-payments and deductibles are payable at the time of the service.

Date

X _____
Signature of patient or legal guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered and/or received a copy of Oakland Colon & Rectal Associates, P.C., Notice of Privacy Practices.

Date

X _____
Signature of patient or legal guardian

If there are specific persons you would want us to discuss your medical information and/or treatment with please list their names below. Written authorization is required to release medical and billing information.

