

INSURANCE AUTHORIZATION

I hereby authorize **Columbus W. Floyd, M.D.** to furnish information to my insurance carriers concerning my illness and or treatment.

ASSIGNMENT OF BENEFITS

I hereby assign to **Columbus W. Floyd, M.D.** all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance company.

CONSENT FOR TREATMENT

I am authorizing consent for treatment by **Columbus W. Floyd, M.D.** for myself or my dependent. I understand a separate consent will be needed for surgical procedures.

SIGNATURE _____ DATE _____

OTHER INSURANCE INFORMATION

Is the patient covered by any other health plan ? YES ____ NO ____

Is other health coverage available through spouse's employer? YES ____ NO ____

IF ANY OF THE ABOVE ARE ANSWERED "YES", PLEASE COMPLETE SECONDARY INSURANCE INFORMATION ON THE PREVIOUS PAGE.

I hereby certify that the above statements are correct.

SIGNATURE _____ DATE _____

MEDICAL DIRECTIVES

I give my permission for Dr. Floyd or his staff to discuss my medical care, including treatment, diagnosis, and test results with the following family member or friend:
(PLEASE LIST TWO NAMES ONLY)

_____, Relationship _____

_____, Relationship _____

Signature Date