THE MAGNOLIA MEDICAL GROUP

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AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION
AND
AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby grant **Vincent Galiano, M.D. P.A.** or its designated representative(s) the authority to seek, receive, and release any and all information pertaining to me as may be necessary to process my insurance claim(s) and to bill and receive payment from my insurance company for any and all services rendered to me by **Vincent Galiano M.D. P.A**. or its designees.

I hereby agree to pay **Vincent Galiano M.D. P.A**.in a timely fashion, for any and all services rendered which may or may not be covered by my insurance. This includes all co-payments and/or insurance payments which I may receive as a result of services rendered by **Vincent Galiano M.D. P.A.** I further agree that if collection becomes necessary, I will pay all costs of collection of my balance including reasonable attorney fees.

CONSENT FORM FOR DIAGNOSTIC AND/OR THERAPEUTIC PROCEDURE.

Thereby consent to and authorize **Vincent Galiano M.D. P.A.** and other health professionals, as designated, to perform a physical examination and routine diagnostic procedures upon me. I also consent to and authorize **Vincent Galiano M.D. P.A.** to prescribe a therapeutic regime, which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) ordered by **Vincent Galiano M.D. P.A.** to be performed on me despite the risk involved and complications that might be involved which were explained to me at the time they were considered.

CONSENT FOR REFERRALS TO SPECIALISTS OR DIAGNOSTIC TESTING

If I am referred out to another doctor or for any testing needed, I authorize **Vincent Galiano M.D. P.A.** to send the necessary information needed to be treated or for a test to be done. The information sent may include office notes, any testing, personal information to contact the patient, and billing information.

PLEASE PRINT AND SIGN NAME

Print Name: _____ Date: _____

Patient Signature: _____ Date: _____

Witnesses: _____ _____