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Authorization/Consent to Provide Care and Bill Insurance

Patient: _____ DOB: _____

Parent/Guardian (if applicable): _____

I am hereby consenting to treatment as may be deemed necessary or advisable in the diagnosis and treatment of my care.

I give my authorization to use or disclose my protected health information (medical records) that may be required in order to administer any treatment deemed necessary in the diagnosis and treatment of my care.

I hereby authorize payment directly to Total Sports Care from my insurance company. I realize that all charges incurred by me are my financial responsibility and all court fees, attorney fees or other fees necessary to collect this amount are payable by me.

Patient Signature

Date

Parent/Guardian Signature (if applicable)

Date

Witness