THE PRACTICE OF PHYLLIS A. RAGLEY, DPM

CONSENT TO RECEIVE TREATMENT

I HEREBY AUTHORIZE DR. RAGLEY AND ASSOCIATES TO ADMINISTER SUCH TREATMENT AND MINOR OPERATIVE PROCEDURES AS MAY BE NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION(S).

_____ _____
SIGNATURE **DATE**

_____
RELATIONSHIP IF NOT PATIENT

AUTHORIZATION FOR INSURANCE PAYMENT

I AUTHORIZE INSURANCE PAYMENT DIRECTLY TO DR. RAGLEY AND ASSOCIATES FOR THE MEDICAL AND/OR SURGICAL BENEFITS OTHERWISE PAYABLE TO ME FOR THOSE SERVICES RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT PAID THROUGH MY INSURANCE POLICY.

_____ _____
SIGNATURE **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES FOR THE DR. PHYLLIS A. RAGLEY PRACTICE

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ, OR HAD THE OPPORTUNITY TO READ IF I HAD SO ELECTED, AND UNDERSTOOD THE NOTICE.

_____ _____
PATIENT NAME (PLEASE PRINT) **DATE**

_____
PARENT OR AUTHORIZED REPRESENTATIVE, IF APPLICABLE

_____
SIGNATURE