INTERNAL MEDICINE ASSOCIATES OF MIDDLE GEORGIA
CRAIG CALDWELL, M.D. JEREMY T. GOODWIN, MD.
TAMMY BARNETT, APRN, FNP-C

Patient: _____ DOB: _____

CONSENT OF TREATMENT: I authorize Internal Medicine Associates of Middle Georgia, office of Craig Caldwell, M.D., Jeremy T. Goodwin, M.D., Tammy Barnett, APRN, FNP-C and staff to furnish the necessary medical treatment that are deemed necessary for the patient named above.

GUARANTEE OF ACCOUNT: I hereby guarantee payment of all charges incurred by the patient identified above.

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