

**THE PRECEDING INFORMATION IS TRUE TO THE  
BEST OF MY KNOWLEDGE.**

**TREATMENT/PAYMENT AGREEMENT FOR CHURN CREEK  
HEALTHCARE:**

I request the above to provide me and/or my family with health care. I authorize the release of information for the purposes of insurance reimbursement to CCHC and other health facilities. Furthermore, I authorize assignment of benefits for health care to be paid to CHURN CREEK HEALTHCARE.