AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize the clinic and the attending physician to release any medical information requested by my insurance carrier for the purposes of reimbursement. I also authorize the release of any necessary medical information to any other physician who is officially consulted about my condition. The Privacy laws require your authorization to permit us to send assigned claims to Medicare. I authorize any holder of medical information about me to release to Medicare, the healthcare financial administrator and its agents, and all information needed to determine these benefits payable for related services.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment of benefits directly to the clinic which would otherwise be payable to me. This includes all major medical and/or surgical benefits but not to exceed the usual and customary charges for these services. I further understand that I am financially responsible for these charges should my insurance company refuse to pay for whatever reason. I also certify that the information given by me concerning my deductible payments is true and accurate to the best of my knowledge.

PAYMENT GUARANTEE: I understand that I am financially responsible for payment of all services incurred by the patient named below.

CONSENT FOR TREATMENT: I hereby authorize the performance of any medical and or surgical procedures-including local anesthesia-which may be advised and recommended by my attending physician while I am an active patient at this clinic.

_____ _____

SIGNATURE DATE

_____

PRINT NAME OF PATIENT

_____

RELATIONSHIP TO PATIENT