RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM

SIGNATURE (PATIENT/GUARDIAN) _____

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO ASSOCIATED GENERAL SURGEONS FOR PROFESSIONAL SERVICES RENDERED

SIGNATURE (SUBSCRIBER) _____

MEDICAL RECORDS

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO ASSOCIATED GENERAL SURGEONS

SIGNATURE: _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. EACH PATIENT IS RESPONSIBLE TO FURNISH OUR OFFICE WITH THEIR INSURANCE CLAIM INFORMATION. THE PATIENT OR GUARDIAN IS RESPONSIBLE FOR ALL FEES REGARDLESS OF COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICE WHEN RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE.

PAST DUE ACCOUNTS

ACCOUNTS FORWARDED TO COLLECTIONS WILL HAVE AN 18% COLLECTION FEE ADDED TO THE BALANCE AND WILL BE THE PATIENT'S RESPONSIBILITY. ACCOUNTS OVER 90 DAYS ARE CONSIDERED DELINQUENT. IN THE EVENT LITIGATION IS NECESSARY, YOU ARE LIABLE FOR COURT AND ATTORNEY FEES. THERE IS A $25.00 FEE CHARGE FOR INSUFFICIENT FUNDS.

I have read and agree to the Terms of this Financial Policy:

_____ **Date** _____ **Patient**

_____ **Date** _____ **Witness**