TO THE PATIENT:

If you are covered by medical insurance, this office will be glad to file the claim for you. You are responsible for all deductibles, co-pays and non-covered services.

If you have any questions or you are not covered under medical insurance, please contact the account's manager at (251) 433-2609. We will be glad to answer your questions or make arrangements for you.

- **By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations.**

PATIENT'S SIGNATURE: _____

- **I AUTHORIZE PAYMENT OF MEDICAL BENEFITS to the undersigned physician or supplier of services rendered:**

SURGICAL ASSOCIATION OF MOBILE, P.A.

INSURED SIGNATURE: _____

- **In consideration for the care and services to be rendered while a patient, I agree to pay all medical expenses (if covered by insurance, all deductibles, co-pays and non-covered services) and, in the event it becomes necessary to take legal action for the collection of said expenses from me, I agree to pay all reasonable attorney fees and collection expenses.**

PATIENT'S SIGNATURE: _____

GUARANTOR'S SIGNATURE: _____

WITNESS: _____ **DATE:** _____