SHOALS SURGICAL GROUP, LLC
AUTHORIZATION

Patient Name_____

I AUTHORIZE Shoals Surgical Group, LLC to perform medical treatment. I certify that the signature below shall serve as **Signature on File** for Medicare, Medicaid, and all insurance companies for claims filed on my behalf by Shoals Surgical Group, LLC. I assign the benefit payable for physician services to Shoals Surgical Group, LLC and authorize Shoals Surgical Group, LLC to submit a claim to Medicare, Medicaid, and all insurance companies for payment.

I AUTHORIZE any physician, medical practitioner, hospital, clinic or other medical or medically related facility, peer review organization, insurance or reinsuring company, the Healthcare Financing Administration, the Medical Information Bureau, Inc. consumer reporting agency, employer or third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, and/or Acquired Immunodeficiency Syndrome (AIDS) and/or tests for or infection with Human Immunodeficiency Virus (HIV), and/or treatment of me or my dependents to give to the group policyholder, my employer, third party administrator, my third party carrier or its legal representative, any and all such information.

I UNDERSTAND the information obtained by this authorization will be used to determine eligibility for insurance, and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal service in connection with the claim, or as may be otherwise lawfully required or as I may further authorize. I UNDERSTAND that information disclosed pursuant to this release may be redisclosed by the authorized recipient and not longer protected by the privacy rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I UNDERSTAND that my medical history is strictly confidential. Absolutely NO information will be released without proper legal consent, unless so deemed by laws of this state.

PAYMENT OF BENEFITS

I AUTHORIZE payment of medical benefits be made to Shoals Surgical Group, LLC.

I UNDERSTAND that I am financially responsible to Shoals Surgical Group, LLC for charges not covered by this authorization and for any portion of charges not covered by this authorization and for any portion of charges for my care not covered by my insurance. Your co-payment and / or deductibles are determined by you insurance company. We are required to collect these fees, to ensure the insurance policy is enforced. Please understand that payment of your bill is considered in part the responsibility of the patient. In the event of nonpayment of charges for medical service rendered, I agree to pay all cost of collection, including a reasonable attorney's fee and court costs and hereby waive all rights of exemption under the Constitutional Laws of the State of Alabama. I further understand that there will be a $30.00 fee for each returned check. I have read this contract and understand its provisions.

AUTHORIZATION TO LEAVE MESSAGES

I authorize Shoals Surgical Group, LLC physicians and staff to leave messages regarding my medical condition, such as lab reports, other test results, medications, and appointment reminders on my home answering machine. This authorization will be in effect until I have given written notice to Shoals Surgical Group, LLC.
Agreed____ Disagree___

AUTHORIZATION TO REVEAL MEDICAL INFORMATION

I authorize Shoals Surgical Group, LLC physicians and staff to reveal to the following individuals, as needed, information regarding my protected health information. I understand that once this information is disclosed to those individuals that Shoals Surgical Group, LLC will not have control over to whom these individuals may reveal this information. I may revoke this authorization by giving written notice to Shoals Surgical Group, LLC.

1) Name_____Relationship_____

2) Name_____Relationship_____

Signed_____Date_____
(Patient, or Parent if Minor)

Insured or Guardian's Signature_____Date_____