OnCall Medical Clinic of Ocean Springs

CONSENT/AUTHORIZATION FORM

Consent for Treatment. I authorize *OnCall* Medical Clinic of Ocean Springs to perform treatment(s)/procedure(s) as deemed necessary for my illness or injury.

Release of Medical Records. In order to assure proper follow-up and continuity of care, I agree that a copy of my medical records may be released to my physician, a designated referral physician, specialist and/or the provider, if any, who referred me here.

Signed_____ Date_____

Patient or person authorized to consent for patient

Insurance Authorization. I request that payment of authorized benefits be made to the *OnCall* Medical Clinic of Ocean Springs on my behalf, for any services provided for me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original.

Medicare Insurance Authorization. I request that payment of authorized Medicare benefits be made either to me or, on behalf of Dr. Aldridge/*OnCall* Medical Clinic of Ocean Springs, for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits.

Payment Policy. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. In the event a debt should become delinquent and requires the aid of an attorney, collection agency, credit bureau, or court, a 40% service fee will be added to the patient's unpaid balance.

Signed_____ Date_____

Patient or person authorized to consent for patient