AUTHORIZATION FOR TREATMENT AND BILLING
Family Medical, PC, 1407 Baddour Parkway, Lebanon, TN 37087

AUTHORIZATION FOR MEDICAL TREATMENT
I authorize the physicians and physician extenders at Family Medical, PC to conduct and direct my medical care. I also authorize Family Medical, PC staff, directed by my physician, to give medications, perform diagnostic procedures, and provide other care which, in the judgment of my doctor, is required for my best care and treatment.

ASSIGNMENT OF BENEFITS
I direct and authorize payment directly to my physician for all monetary benefits available to me. It is expressly understood and agreed that acceptance by the said hospital, of benefits under this policy, shall in no way operate to release the person responsible for payment of the services referred to herein from his or her obligation to pay for all charges not covered by my insurance policy or excess of said policy limits.

GUARANTEE OF PAYMENT
For value received, the undersigned hereby unconditionally guarantees the prompt payment of all its charges, hereby agreeing to pay all cost and expenses incurred in enforcing this guarantee. In the event the patient or guarantor fails to comply with their obligation herein, each consents to the disclosure of their identity and any other necessary information relating to service rendered to the patient by the attending physician to any collection agency or attorney at law, for the purpose of enforcing the patient's or guarantor's obligation to the health group and the re-disclosure of such information by the collection agency or attorney. Such disclosure or re-disclosure shall not be deemed to be a breach of the patient confidentiality by the health group.

RELEASE OF WRITTEN AND/OR VERBAL INFORMATION FOR BILLING AND UTILIZATION REVIEW PROCESS
I authorize my physician to release written and/or verbal information from my medical record, as necessary, to process my insurance claims and for utilization review when justification for treatment or continued treatment is required.

MEDICARE ASSIGNMENT AND AGREEMENT TO PAY MEDICARE NON-COVERD CHARGES
I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician to release to the Social Security Administration and/or its intermediaries and/or carriers any information needed for this or any related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician organization furnishing these services, or authorize the above to submit a claim to Medicare for payment to me. I understand Medicare Participating Physicians have been advised by the Centers for Medicare & Medicaid Services (CMS) that services provided to Medicare Beneficiaries, which are determined by CMS to be unnecessary, will not be paid for by Medicare. The physician may not collect for these services from the patient, unless an Advanced Beneficiary Notification (ABN) has been signed by the patient at the time services were rendered.

By signing below, I am verifying that I have read all of the above statements and agree to each statement.

X_____ _____
Patient Signature DATE
Patient/Legal Guardian

X_____ _____
Witness DATE