

Lillian Medical Clinic
P.O. Box 389
Lillian Al. 36549
(251) 962-4362
Fax; 962-4363

Patient Name _____
DOB _____

PATIENT AUTHORIZATION

AUTHORIZATION FOR MEDICAL/SURGICAL TREATMENT

The undersigned hereby consents and authorizes Lillian Medical Clinic, its physicians and staff to perform such treatments, services procedures, diagnostic studies and to provide such care as may be necessary, appropriate and/or medical care may require the combine participation of physician, assistants, nurses and other personnel, I hereby consent to medical and technical services and procedures by such procedure physician and personnel. I understand and acknowledge that the practice of medicine and surgery is not an exact science and diagnosis and treatment may involve risk of injury or death. No guarantees have been given to me by anyone to the result that may be obtained as a result of any such service or treatment.

RELEASE OF INFORMATION

The undersigned hereby consents and authorizes Lillian Medical Clinic, its physicians and staff to complete, convey and release my medical records for purpose for receiving payments for services rendered. This shall include any and all medical histories, records, reports, summaries, diagnosis, as well as any drug/alcohol related condition, psychiatric or psychological conditions and communications, treatment or testing for Acquires Immune Deficiency Syndrome, and other written or graphic material of any type prepared, kept, made or maintained by or behalf of Lillian Medical Clinic or its affiliates in any way pertaining to any type rendered to or received by me.

ASSIGNMENT OF BENEFITS

I hereby assign to Lillian Medical Clinic any and all third party payer/insurance benefits and or payments for which I am eligible as a result of any treatment Lillian Medical Clinic including but not limited to Medicare, Blue Cross Blue Shield and/or other insurance programs of any type and I hereby request that payment of such benefits or payments be made on my behalf by such person or entity directly to Lillian Medical Clinic.

RESPONSIBILITY FOR PAYMENT

The undersigned, in consideration of the services to be rendered to the patient, to hereby agree jointly and individually to pay and to guarantee payment of the account of the patient in accordance with the regular rates and terms of Lillian Medical Clinic. If the account is referred for collection by Lillian Medical Clinic to an attorney or collection agency, the undersigned agree(s) to pay all attorney's fees and other reasonable cost of the collection agency that are necessary for the collection of any amounts not paid when due whether or not suit is filed.

Signature of Patient Date

OR

Authorized Representative Date

LMC Employee Date

Relationship to Patient Date