Birmingham Surgical, P.C.

AUTHORIZATION FOR DIAGNOSTIC SERVICES AND/OR MEDICAL TREATMENT

I, the undersigned, a patient of BIRMINGHAM SURGICAL, P.C., hereby authorize this clinic to administer such diagnostic/medical services considered necessary based on the findings of the attending physician. I understand that no guarantee has been (or will be) made to me as a result of diagnostic findings and/or medical treatment. I hereby certify that I have read and fully understand this Authorization for Diagnostic Services and/or Medical Treatment.

AUTHORIZATION MUST BE SIGNED PRIOR TO DIAGNOSTIC/MEDICAL SERVICES.

PATIENT'S SIGNATURE (or Mark) ____

SIGNATURE OF PARENT/GUARDIAN/RELATIVE ____________________________________
(REQUIRED if patient is a minor or physically/mentally unable to sign Authorization)

RELATIONSHIP TO PATIENT ______________________________ DATE ____________

SIGNATURE OF WITNESS ____

CONCERNING INSURANCE

All professional services are charged to the patient. Necessary forms will be submitted to your insurance carrier(s) based on the information you have furnished. We are **REQUIRED** to submit claims to **ALL** insurance carriers with which you are enrolled for MEDICAL benefits. If you are covered by more than one policy, we **MUST** file with your PRIMARY carrier first, SECONDARY next, etc. Should payment be made directly to patient, you must send us a copy of the EXPLANATION OF BENEFITS before we will be able to file with any other insurance company. As a service, at no charge to you, we file claims with all carriers you list on our information sheet. If you have not given us all information at the time of service, there will be a charge for other claims filed – due to additional time involved in reprocessing notifying first carrier of other coverage, possible refilings/refunds to companies with which we originally filed, etc.).

The patient (parent/guardian) is responsible for all fees—-regardless of insurance coverage. Should benefits be paid directly to policy holder by insurance company, you should forward payment to Birmingham Surgical, P.C., (along with a copy of the EXPLANATION OF BENEFITS) to be applied to any unpaid balance on your account.
****WE CANNOT FILE WITH YOUR SECONDARY CARRIER WITHOUT A COPY OF THE EXPLANATION OF BENEFITS.** **Please **READ** and **SIGN** the following authorization and assignment.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize BIRMINGHAM SURGICAL, P.C., to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to BIRMINGHAM SURGICAL, P.C., all payments for medical services rendered to myself or my dependent. I understand that any **"Hold Harmles**s" provision written into the contract does not apply unless BIRMINGHAM SURGICAL, P.C., is a member of the carrier's plan. I understand that I am responsible for any amount not covered by insurance. I agree to pay the difference or the entire balance, if necessary.

PATIENT'S SIGNATURE ____
INSURED'S SIGNATURE ____
Insured or Responsible Party

INSURANCE AUTHORIZATION **MUST BE SIGNED** PRIOR TO SERVICES BEING RENDERED.