

**Release of Medical Information:**

I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Dr. Joycelyn M.Theard. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original.

**Financial Agreement:**

The charges for today's services will be billed to the listed insurance carrier(s) for payment, if the insurance information is adequately provided. Whether signing as the patient or his/her agent, I agree that in consideration of the services rendered I shall be individually responsible to pay Dr. Joycelyn M. Theard for all services at the regular rates and terms should my insurance company deny payment. I shall also be responsible for any deductibles or co-pay amounts owed at the time of service. I understand that my account must be paid in full sixty (60) days from the date of service, if not by the insurance carrier, then by me, as the responsible party. Should this account be referred to any attorney or collection agency, I shall pay all attorneys' fee and collection expenses in connection therewith, if the patient's account is delinquent.

**Assignment of Benefits:**

I hereby assign the benefits due to me to Dr. Joycelyn M. Theard. I authorize and instruct the insurance carrier to make payments of authorized benefits directly to Dr. Joycelyn M. Theard. I understand that I am responsible for charges not paid by my insurance company. I authorize release of all records required to act on this request. I also authorize Dr. Joycelyn M. Theard to initiate a complaint to the insurance commissioner for any reason on my behalf.

**For Medicare Beneficiaries:**

PATIENTS CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act of this request. I request that payment of authorized benefits be made on my behalf.

**For Medicaid Beneficiaries:**

PATIENTS CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the services(s) covered by this claim has been received, and I request that payment for these service(s) be made on my behalf. I authorize any holder of medical or other information about me to release any information needed for this or a related claims.

I hereby acknowledge that I have read this form. A copy of this assignment is as valid as the original.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Parent of legal guardian if patient is a minor)