

CLOVIS E. MANLEY, MD, LLC

Patient Name _____ Account Number _____

AGREEMENT TO PAY/AUTHORIZATION FOR INSURANCE PAYMENT

I agree to pay for all fees or my portion not covered by medical insurance for the above mentioned patient, at the time of service. I realize I am also responsible for full payment of fees, not paid by insurance, within 30 days of notification by Clovis E. Manley, MD, LLC. I also agree to be responsible for any fees required to collect payment for services including: attorney and court costs, collection agency fees, pre-judgment and/or post judgment interest at the current legal rate.

I hereby authorize my insurance company to make payment directly to Clovis E. Manley, MD, LLC, unless I pay in full at the time of service.

Signature _____ Printed Name _____ Date _____

COLLECTION FEE

I understand that if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33% will be added to my account. I agree to pay that fee. I further agree to pay reasonable attorney fees and court costs. I understand and agree to the above terms.

Signature _____ Printed Name _____ Date _____

(OVER)

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits for any services furnished to me by Clovis E. Manley, MD, LLC (or any party who accepts assignment) be made to either me or on my behalf to Clovis E. Manley, MD, LLC. I authorize the holder of medical or other information to release to the Health Care Financing Administration (Medicare) and its agents, any information needed to determine these benefits or benefits for related services. I further authorize Clovis E. Manley, MD, LLC to release any information needed for this or any related Medicare/Medicaid claim to the Social Security Administration or its intermediaries or carriers.

Signature _____ Printed Name _____ Date _____

MEDICAL RECORDS RELEASE

If it is necessary for any of my medical records, including progress notes and laboratory results, to be sent to another health care provider for medical reasons and to facilitate timely healthcare, I authorize Clovis E. Manley, MD, LLC to do so.

I also authorize the release of medical information, necessary to process my claim, to my insurance company, Workman's Comp plan, Social Security, Medicare/Medicaid, or any representatives acting on their behalf.

I further authorize the release of my medical records to any individual or organization, engaged by Clovis E. Manley, MD, LLC, my physician, or my third party payer (insurance company), to conduct quality improvement and/or utilization review. I permit a copy of this authorization to be used in place of the original. I hereby release Clovis E. Manley, MD, LLC from all legal liability that may arise from the disclosure of such information.

Signature _____ Printed Name _____ Date _____

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