

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICE UNLESS COVERED BY "SPECIAL HEALTH CARE PLAN" OR MEDICARE, OTHERWISE FINANCIAL ARRANGEMENTS MUST BE MADE BEFORE MEDICAL TREATMENT.

AUTHORIZATION TO RELEASE MEDICAL RECORDS: I AUTHORIZE SPCCSM TO REALEASE ALL MEDICAL RECORDS AND PERTINENT MEDICAL INFORMATION TO ANY INSURER, GOVERMENTAL AGENCIES PROVIDING BENEFITS, OR TO ANYONE LIABLE FOR CHARGES. I ALSO AUTHORIZE RELEASE OF MY PROTED HEALTH INFORMATION TO MY REFERRING PHYSICIAN AND TO OTHER MEDICAL PROVIDERS OR OBSERVERS WHO ARE OR MAY BECOME INVOLVED IN MY TREATMENT OBSERVATION. ADDITIONALLY, I UNDERSTAND I AM RESPONSIBLE FOR THESE CHARGES REGARDLESS OF INSURANCE COVERAGE. IF THIS ACCOUNT IS PLACED WITH AN ATTORNEY OR AGENCY FOR COLLECTION, I HEREBY AGREE TO PAY ANY REASONABLE AND NECESSARY COLLECTION FEES.

CONSENT TO USE OR DISCLOSURE: I CONSENT TO SPCCSM USE OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT OF HEALTH CARE OPERATIONS.

**** CHECK HERE IF YOU DO NOT WISH FOR ANY INFORMATION CONCERNING YOUR MEDICAL CARE TO BE LEFT ON A HOME ELECTRONIC ANSWERING DEVICE, INTERNET, E-MAIL ADDRESS, OR FACSIMIL USING ANY PHONE NUMBERS, E-MAIL ADDRESSES DISCLOSED ON THIS FORM.**

INSURANCE ASSIGNMENT: I HEREBY AUTHORIZE SPCCSM TO FURNISH CLAIMS INFORMATION TO MY INSURANCE CARRIES/PLANS REGARDING MEDICAL CONDITION AND TREATMENT, AND , I HEREBY ASSIGN TO SPCCSM ALL INSURANCE PAYMENTS FOR MEDICAL SERVICES RENDERED ON MY BEHALF FOR MY DEPENDENTS FOR CREDIT AGAINST MY ACCOUNT ON BILLINGS RELATED TO THOSE SERVICES RENDERED.

PATIENTS SIGNATURE: _____ DATE: _____

*******For Office use only*******

W/C CONFIRMED: YES NO

AUTHORIZING PERSON'S NAME: _____

W/C INS. CO. NAME: _____

ADDRESS: _____