**mississippibreastcenter.com**
**PHILLIP B. LEY, MD, FACS**

# *SIGNATURE FORM*

## FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

I understand that i am financially responsible to surgical clinic associates, p.A. For charges not covered by my insurance carrier. Payment for services is due at time of service unless prior arrangements have been made. I also agree that, should i fail to assume this financial responsibility and credit action is necessary, i will pay for these costs in addition to the amount of the doctor's charges. I authorize surgical clinic associates, p.A. To release to the social security administration or its intermediaries or carriers, or other insurance carrier any medical or other information needed for this or a related insurance claim. A copy of this authorization may be used in place of the original.

_____ X_____

**DATE** **SIGNATURE OF PATIENT OR GUARDIAN**

## EXTENDED PAYMENT REQUEST (ONE TIME AUTHORIZATION) (MEDICARE AND MEDICAID PATIENTS ONLY)

I request that payment of authorized medicare benefits or other insurance benefits be made on my behalf to surgical clinic associates, p.A. For any services furnished to me by that provider. This one time signature will be maintained on file as verification for all subsequent services which are provided to me by this provider. I authorize any holder of medical information about me to release to the centers for medicare and medicaid services and its agents or other insurance carriers any information needed to determine these benefits or benefits payable for related services.

_____ X_____

**DATE** **SIGNATURE OF PATIENT OR GUARDIAN**

## MEDIGAP AUTHORIZATION (MEDICARE PATIENTS ONLY)

i request that payment of authorized medigap benefits is made on my behalf to the surgical clinic associates, p.A. For any services furnished by that provider. I authorize any holder of medical information about me to

RELEASE TO_____ANY INFORMATION NEEDED TO

DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

MEDICARE NUMBER_____

SECONDARY INSURANCE_____POLICY #_____

_____ _____

**DATE** **SIGNATURE OF PATIENT OR GUARDIAN**