SOUTHERN CARDIOVASCULAR ASSOCIATES, PC

Authorization To Pay Physician

I authorize payment of any medical benefits to the physician providing the medical services submitted for payment that would have otherwise been payable to me. I understand that any amount deemed by my insurance carrier to be beyond the "usual, reasonable, and/or customary" charges for said services will be paid by me.

Authorization To Release Information

I hereby authorize any physician of Southern Cardiovascular Associates, P.C. to release any information acquired in the course of my examination or treatment to my insurance company.

Non-Covered Procedures

As your physician, I want to provide you with the best care possible. There may be certain routine services that I feel are necessary for the maintenance of good health that are not covered by your insurance contract or may be considered "medically unnecessary". For example, I may order lab tests, chest x-ray, EKG or injections that may not be covered by your contract. There may also be tests required that may be only partially paid by your primary or secondary insurance coverage. In this event, you will be responsible for the balance.

I have been notified by my physician/supplier that my insurance company may deny payment for any claim for services that it determines not to be responsible and/or necessary. It may also deny payment for services considered to be routine.

You will be notified before any procedure is done that you will be responsible for.

I accept the responsibility for immediate payment of the charges not covered by my insurance company.

Payment Terms

As consideration for the physician's services, I agree to pay all charges for services at the completion of such services. As agreed, the physician may, at his/her discretion, place the unpaid account with any attorney's fees, court costs, and any other reasonable costs of collection.

I understand that a check returned by my bank for any reason is subject to a reasonable service charge by Southern Cardiovascular Associates, P.C.

I understand that the terms listed here are binding throughout my medical treatment by Southern Cardiovascular Associates, P.C.

I have read and understand the statements on this form.

Signature _____ Date _____