Patient name:______________________________ Chart #:______________________

WILLIAMS COMPREHENSIVE HEALTHCARE PLLC
AUTHORIZATION TO PROVIDE TREAMENT
INSURANCE ASSIGNMENT AND RELEASE

I hereby authorize the providers of Williams Comprehensive Healthcare PLLC or any other medical provider authorized by it, to provide such medical services, either regular or emergency, as may be determined by the medical provider to be in my best interests (or the best interests of my dependent if I am signing as a parent or guardian).

Further, I hereby assign, transfer and set over to Williams Comprehensive Healthcare PLLC all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with the insurance policy(ies) listed below or any other third-party payor that may be responsible for paying me for these services. Should payment be made directly to me, I agree to immediately endorse such payment to Williams Comprehensive Healthcare PLLC.

In those cases where payment is not collected at the time of service, I understand that I am responsible for the cost of the medical services rendered and agree to pay any and all amounts not paid by others within niney (90) days from the date billed unless there are other agreements between me or my insurance company and Williams Comprehensive Healthcare PLLC. I agree to pay all collection costs including, but not limited to bad check charges, court costs, witness expenses and reasonable attorney's fees if it becomes necessary to turn this account over to an outside party for collection. I further agree to pay an interest charge of 1% (one percent) per month on any balance remaining on this account beginning ninety (90) days from the date of service. If at any time a single visit is overpaid and amounts from other visits remain unpaid, I agree that Williams Comprehensive Healthcare PLLC may apply the overpayment from one visit to outstanding balances from other visits. I understand that a refund will not be issued to me until all visits are paid and full and my account retains a credit balance.

I understand that it is my responsibility to know the requirements of my insurance policy and comply with them. If the providers of Williams Comprehensive Healthcare PLLC do not participate in my plan, I agree to be responsible for any costs not paid by my insurance company. Further, if my plan requires a referral, I agree it is my responsibility to obtain the referral. If I do not obtain such a referral and my plan does not pay because of my failure to do so, I agree to be responsible for the costs of my treatment. If my plan requires precertification for certain services, I agree to inform Williams Comprehensive Healthcare PLLC of these requirements and to be responsible for any bill if I did not inform them of the precertification requirements.

I specifically give Williams Comprehensive Healthcare PLLC the authority to release my medical records to any medical provider who needs access to them to provide appropriate medical care. Further my medical records may be released to those who perform Williams Comprehensive Healthcare PLLC's billing services and to any third-party payors who are responsible for my bill. I have been given a copy of Williams Comprehensive Healthcare PLLC's privacy guidelines and been given the opportunity to object to other listed reasons for release.

These authorizations and releases remain in effect until I choose to revoke them by delivering a written statement to Williams Comprehensive Healthcare PLLC.

Patient/Responsible party:______________________________________ Date:______________________

Insurance company(ies):____

___________________________________and any insurance companies that I may use in the future.

Medicare patients with Medigap Insurance:

I request that payment of authorized Medigap benefits be made on my behalf to Williams Comprehensive Healthcare PLLC for any services furnished me by that supplier. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits. This authorization is in effect until I choose to revoke it.

Patient/Responsible party:______________________________________ Date:______________________

(Authorization to treat.doc)