Payment/ Insurance Authorization

By signing below:

I hereby authorize Mississippi Ear, Nose and Throat Surgical Associates, P.C. to file my insurance claim for the services received in the office and any physician in this group (which includes Stephen F. Lee M.D., Benjamin T. Jeffcoat M.D., Beverly C. Fulcher, M.D. and/or J. Peyton Hines M.D.).

I hereby authorize Mississippi Ear, Nose and Throat Surgical Associates, P.C. to receive payment directly for my insurance benefits, including major medical, payable under the terms of your insurance contract.

I hereby authorize Mississippi Ear, Nose and Throat Surgical Associates, P.C. to release/send any medical information acquired in the course of treatment to my insurance company listed above that is needed for inquiries or to process your claim.

I hereby authorize photocopies of this form to be valid as the original.
I hereby agree to be responsible for the payment of this account, including co-pays, deductibles, co-insurance, return check fees and non-covered amounts. Payment is due at the time of service.

If l am under 18, then the parent/guardian requesting treatment assumes responsibility.

"I agree to pay up to 33 % of the unpaid balance for collection fees, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that I am responsible for reasonable collection costs and in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court."

Signature _____ **Date** _____

(If patient is a minor) Patient's Name: _____

Mississippi Ear, Nose & Throat SURGICAL ASSOCIATES

Consent to Treat

*** I _____ do give the listed physicians:**
(Name of Patient)

Stephen F. Lee, M.D., Benjamin T. Jeffcoat, M.D., Beverly C. Fulcher, M.D., J. Peyton Hines, M.D. and their clinical staff, permission to administer medical treatment to myself or my child
_____.
(Name of Patient)

*I authorize them to use their medical judgement in the treatment of the (above mentioned patient) so long as myself / he/ or she is under their care.

_____	_____	_____
Patient or Guardian's Signature	**Relationship to Patient**	**Today's Date**

_____	_____
Clinic Staff Witness	**Today's Date**