PAULA J. WILSON, D.C.
AUTHORIZATION AND CONSENT

Name of Beneficiary_____ H.I. Claim Number_____

MEDICARE

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to PAULA J. WILSON, D.C. for any services furnished me by PAULA J. WILSON, D.C.. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable to related services. I permit a copy of this authorization be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

MEDIGAP

I request that payment of authorized Medigap benefits be made on my behalf to PAULA J. WILSON, D.C. for any services furnished me by PAULA J. WILSON, D.C.. I authorize any holder of medical information about me to release to _____, any information needed to determine these benefits payable for related services.

COMMERCIAL

ASSIGNMENT OF INSURANCE BENEFITS: I irrevocably assign all payments to PAULA J. WILSON, D.C. for medical insurance benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to PAULA J. WILSON, D.C. for services performed during this period of treatment. In making this assignment, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

RELEASE OF INFORMATION: PAULA J. WILSON, D.C. may disclose any or all parts of the clinical record to me (our) insurance company(s) or employer(s) for purposes of satisfying charges billed by PAULA J. WILSON, D.C.. I further understand that it may be necessary for PAULA J. WILSON, D.C. to contact my (our) past or present employer(s) in regards to this claim.
This authorization does not cover 3rd party liability claims.

GUARANTEE OF ACCOUNT: PAULA J. WILSON, D.C.
For and in consideration of services rendered by PAULA J. WILSON, D.C. to the below named patient, the undersigned (jointly and severally, if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills. There will also be added 35% collection and reasonable attorney fee if your account goes to a collection agency.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

_____ _____
Patient's Signature Registration Date

_____ _____
Patient's Agent Representative & Guarantor Signature Registration Date

Name of Patient _____