PLEASE READ AND SIGN

IF THE PATIENT HAS NO INSURANCE, THE PATIENT IS RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE

IF THE PATIENT HAS INSURANCE, THE CO-PAY IS DUE AT THE TIME OF SERVICE

PLEASE READ AND SIGN

CURRENT INSURANCE CARD, MEDICARE, AND MEDICAID CARD IS DUE AT TIME OF SERVICE
I UNDERSTAND THAT DR. POLHILL WILL FILE MY ISURANCE FOR ME AND I AGREE
THAT I AM RESPONSIBLE FOR ANY FEES NOT COVERED BY INSURANCE

I HEREBY AUTHORIZE DR JOHN POLHILL , JR. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS, AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICE RENDERED TO MY DEPENDENT OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. BY SIGNING BELOW, I AM IN AGGREANCE THAT ALL OF THE INFORMATION PROVIDED IN THIS DOCUMENT IS TRUE AND ACCURATE.

DATE: _____ SIGNATURE: _____

CONSENT TO WIRELESS TELEPHONE CALLS: I AUTHORIZE THIS FACILITY ALONG WITH ANY BILLING SERVICE AND THEIR COLLECTION AGENCY OR ATTORNEY WHO MAY WORK ON THEIR BEHALF TO CONTACT ME ON MY CELL PHONE AND/OR HOME PHONE USING PRE-RECORDED MESSAGES, ARTIFICIAL VOICE MESSAGES, AUTOMATIC TELEPHONE DIALING DEVICES, OR OTHER COMPUTER ASSISTED TECHNOLOGY, OR BY ELECTRONIC MAIL, TEXT MESSAGING, OR BY ANY OTHER FORM OF ELECTRONIC COMMUNICATION.

DATE:_____SIGNATURE_____

CONSENT TO PHOTOGRAPH, VIDEOTAPE, OR OTHER IMAGING

I AUTHORIZE SOUTHERN SURGICAL, PC TO PHOTOGRAPH, VIDEOTAPE, OR DIGITALLY IMAGE ME AS APPROPRIATE FOR MEDICAL RECORD IDENTIFICATION PURPOSES AND/OR TO DOCUMENT MY MEDICAL CONDITION. I RELEASE THE CLINIC, ITS PHYSICIANS, EMPLOYEES, AND AGENTS FROM ANY LIABILITY IN THE MARKING AND USE OF THESE REQUESTED PHOTOGRAPHS, VIDEOS, OR DIGITAL IMAGES.

DATE_____SIGNATURE_____