

Chart #: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
Social Security #: \_\_\_\_\_

Memphis Internal Medicine, P.L.L.C.  
Authorization to Provide Treatment  
Insurance Assignment and Release

I hereby authorize Memphis Internal Medicine, P.L.L.C., to provide such medical services, either regular or emergency, as may be determined by the physician to be in my best interest (or the best interests of my dependent if I am signing as a parent or guardian).

I hereby authorize Memphis Internal Medicine, P.L.L.C., or its agents to furnish information to Medicare, insurance carriers or other third-party payors concerning my illness and treatments. I hereby assign to the physician(s) all payments for medical services rendered to me or my dependents.

I understand that unless arrangements are made by me or my insurance company, I am expected to pay at the time of service. Cash, local checks, Visa or Mastercard will be accepted.

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 thirty (30) days from the date billed unless there are other agreements between me and my insurance company and Memphis Internal Medicine, P.L.L.C. I agree to pay all collection costs including, but not limited to, court costs and reasonable attorney's fees if it becomes necessary to turn this account over to an outside party for collection.

These authorizations and releases remain in effect until I choose to revoke them by delivering a written statement to Memphis Internal Medicine, P.L.L.C.

Patient/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Medicare patients with Medigap Insurance:

I request that payment of authorized Medigap benefits be made on my behalf to Memphis Internal Medicine, P.L.L.C., for any services furnished to me by that supplier. I authorize any holder of medical information about me to release such information if any information is needed to determine these benefits.

This authorization is in effect until I choose to revoke it.

Patient/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_