

AUTHORIZATION/RELEASE OF INFORMATION

I hereby authorize Mountain Brook Plastic Surgery to furnish all available information to my insurance company, to other physicians, and/or hospitals, including but not limited to any illness, medical past, present or future with respect to any illness, medical history, consultation, prescriptions, treatments, hospitalization, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original. This authorization shall continue to be valid indefinitely unless revoked in writing.

I authorize the use of this signature on all insurance submissions.

I hereby authorize Mountain Brook Plastic Surgery to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature: _____ Date: _____

CONSENT FOR TREATMENT/FINANCIAL AGREEMENT

I consent to treatment necessary or desirable to the care of the patient first mentioned above, including, but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, X-ray, or other studies that may be used by the attending doctor, her nurse or qualified designate. I also acknowledge full responsibility for the payment of such services, and agree to pay for them at the time of service. I understand that the charges made for professional services may not be covered in full by insurance although insurance may be filed. I understand that the patient or the responsible party is solely responsible for the payment of all services. If the account becomes delinquent in payment I agree to pay all costs of collection, including a reasonable attorney's fee.

If you have any questions about whether a particular service is covered or not, you will need to check your policy. If you still have questions, usually the insurance company will be glad to answer the questions with a simple phone call. Thank you very much for your understanding.

I HAVE READ YOUR POLICY AND AGREE TO PAY FOR SERVICES NOT COVERED BY MY HEALTH INSURANCE CONTRACT AS INDICATED BY MY SIGNATURE BELOW.

Signature: (Patient, Parent, or Agent) _____ Date: _____

I hereby authorize Mountain Brook Plastic Surgery to receive payments of any medical benefits otherwise payable to me under the terms of insurance for services rendered.

Signature: _____ Date: _____

PLEASE MAKE SURE YOU HAVE FILLED THIS FORM OUT COMPLETELY.

**PLEASE PROVIDE FRONT DESK WITH YOUR INSURANCE CARD AND
DRIVERS LICENSE**

**Sherry Collawn MD, Ph. D
Mountain Brook
Plastic Surgery & Laser Center**

Attn: All Patients

This is a courtesy reminder to check with your insurance carrier to make sure Dr. Sherry Collawn is in your network as well as the hospital that you plan to use for your surgery. These are for your protection and remember the ultimate responsibility is yours. We will be glad to help you if you have any questions. Thank you!

Patient Signature:_____

Date:_____