TUPELO PLASTIC SURGERY CLINIC

ROBERT C BUCKLEY MD

Release of Medical Information

(Family / Personal Contacts)

Tupelo Plastic Surgery Clinic will not discuss your personal health information with anyone except those allowed under federal and state law without your authorization. Please list the names and relationships of those you authorize us to discuss your personal health information with.

Contact Name	Relationship	Phone#
Contact Name	Relationship	Phone#

Medical Release

(For Insurance)

I, _____, do hereby authorize Tupelo Plastic Surgery Clinic to release my medical records (office / consult notes, operative reports, lab results, pathology reports and medical history pertaining to my treatment) to my insurance company for pre-certification and medical determination for payment.

_____

Patient Signature

Patient Financial Agreement

Tupelo Plastic Surgery Clinic appreciates you choosing us for your surgical and medical services. The clinic has the following financial policies:

Insured patients will be required to pay their co-pay for this office visit in full (plus any balance owing to us for prior services) before they leave the office today. If your insurance company does not pay our charges for this and subsequent visits in full you will be responsible for any balance.
All other patients will be required to make payment in full for our charges for this visit before leaving the office today.
If you have a surgical procedure performed at this visit, and / or have one or more procedures scheduled in the future, we will make separate financial arrangements with you for such procedure(s).
I full understand that I am responsible for any and all charges associated with my account that are not covered by my insurance . I will also be responsible for collection fees, court cost, attorney fees and any other charges incurred in the collection of any balance due.

_____ _____

Patient Signature **Date**

_____ _____

Witness **Date**