SOUTHERN CLINIC, P.C.

Medical Insurance Waiver

PLEASE READ BEFORE SIGNING

Dear Patient:

Congress has passed certain policies that were established by Medicare or your health insurance carrier. Therefore some of the medical procedures and tests which I deem advisable or necessary in diagnosing and treating you may have been declared as not medically necessary by Medicare and/or your health carrier.

If such a declaration is made, you will be expected to pay for such services in full. Also, if you do not currently have medical insurance, you will also be expected to pay in full for all services rendered. In my diagnosis and treatment of your health problems, I may feel it is in your best interest to order certain tests, medical treatment, labs, x-rays, etc. which may be declared as not covered, thus leaving you with a responsibility for payment. However, I will only do this if I feel that it is medically necessary.

In ordering such treatments or tests, let me assure you that I will only order such tests that I feel are necessary for your treatment, care and well-being.

If you have questions about whether a particular test or service is covered or how much a particular procedure costs, please request to discuss it with a member of my insurance staff or with myself prior to receiving any treatment. We will be happy to discuss this with you.

Sincerely,
The Physicians and Mid-Level Providers of Southern Clinic, P.C.

I have carefully read the above statement or had someone read it to me and understand that I am to pay for services not covered by Medicare or other health care providers or agencies. It is my duty to notify my providers' office of any change affecting my insurance coverage or to pursue payment by my insurer should they fail to pay a covered charge. In the event I fail to pay for services or expenses related to my treatment by my provider, I personally agree to pay all reasonable costs of collections including a reasonable attorney's fee. This agreement is deemed continuing in nature and will apply to all services and dates of treatment by my provider. In consideration of receiving treatment by my provider, I hereby waive my right to claim exemptions allowed under Alabama law. I also agree to operate in accordance with any and all office policies of my provider in regard to paying for services, etc. I understand that unpaid balances can accrue interest at a rate of 1.5% per month according to Alabama law.

_____ _____

Signature Date

_____ _____

Witness' Signature Date