

TRI-COUNTY SURGICAL ASSOCIATES, P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Tri-County Surgical Associates, P.A., to release my medical information pertinent to payment of medical expenses incurred by me to the insurance carriers named below, or its intermediaries, carriers, agents or billing agents. I permit a copy of the authorization to be used in place of original requests for payment of medical insurance benefits for myself or to the party that accepts assignment.

Insurance Carrier

Policy Number

Insurance Carrier

Policy Number

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign my rights under the above named policy of insurance to Tri-County Surgical Associates, P.A. but not limited to major medical insurance, hospital benefits, or injury benefits. In the event that a third party is deemed liable for my medical condition, I assign my rights under an insurer such as auto insurance, workman's compensation insurance and/or medical, hospital, or disability payments, commonly referred to as "PIP" pursuant to section 56-11-110SC Code of Laws, 1976, as amended, and the proceeds of all claims resulting from the liability of the third party payable by any person, employer, insurance company to or for me up to the full amount of the medical charges incurred. In addition, I further warrant and represent that any insurance assigned is valid insurance and in effect and I have the right to make assignment.

PERSONAL LIABILITY

I expressly understand that I am personally responsible for the entire amount of my medical expenses incurred by me for medical care and treatment either inpatient or outpatient, Any payment received by Tri-County Surgical Associates, P.A. as a result of the above Authorization for Release of Medical Information and Assignment of Insurance Benefits will be credited toward my account. I will be personally liable for any remaining balance on my account. After 30 (thirty) days any balance will incur a 2% (two percent) finance charge monthly.

CONSENT FOR MEDICAL CARE

I hereby authorize Tri-County Surgical Associates, P.A., to render medical treatment, as they deem appropriate under the direction of my physician, associates, partners, and/or designees as selected by him/her to perform such treatment. I recognize that during the course of treatment, conditions may arise that necessitate additional procedures or services and I further authorize and request that my physician and/or his associate, partners, or designee perform such procedures or services as are in his/her best professional judgment. **No guarantees or assurances have been made or given by anyone as to the results that may be obtained by any treatment or procedures rendered to me.**

By signing below, the undersigned certifies that the foregoing paragraphs have been read in full and are understood.

Signature of Patient (Parent/Guardian if minor)

Date

Signature of Guarantor (if different from above)

Date