

PATIENT AGREEMENT AND ACKNOWLEDGEMENT FORM

Raynon A. Andrews, M.D., P.C.

Please initial:

____ **ASSIGNMENT OF INSURANCE RESPONSIBILITY:** I hereby authorize payment of all insurance benefits, basic and major medical for this period of service to be made directly to **Raynon A. Andrews, M.D., P.C.** and any other provider rendering services. If the check must be made out to me, I will send this payment to *Raynon A. Andrews, M.D., P.C at 1878 Jeff Road, Suite A, Huntsville, AL 35806.*

____ **STATEMENT OF FINANCIAL RESPONSIBILITY:** I hereby authorize **Raynon A. Andrews, M.D., P.C.** and any provider rendering services to collect for all charges not covered by insurance payments. I also authorize payment for all collection costs, securing or attempting to collect, including reasonable attorney fees or Collection Agency Fees, whether suit is necessary or otherwise. I understand that all patients who are considered a legal adult are financially responsible for all services rendered.

____ **AUTHORIZED ACCESS:** Patients 14-18 years of age who DO NOT wish parents or guardians copies of their medical record must complete a Restricted Request Form.

The Signature below applies to the items indicated above. I have read and understand this contract and I have willingly signed this document.

Signature: _____ **Date:** _____ **Witness:** _____

CONSENT FOR MEDICAL/EMERGENCY TREATMENT: I hereby consent to and authorize **Raynon A. Andrews, M.D., P.C.**, to render usual and customary medical/emergency treatment, including diagnostic and radiological procedures, minor surgical procedures and administration of local anesthetic necessary and other general medical/emergency treatment.

The Signature below applies to consent for Medial or Emergency Treatment. I have read and do understand this statement and I have willingly signed.

Signature: _____ **Date:** _____ **Witness:** _____

I do not agree with all the items in the Patient Agreement and Acknowledgement and I wish to submit my restrictions in writing to Rayon A. Andrews, M.D., P.C.. I understand that Raynon A. Andrews, M.D., P.C., may not agree with my restrictions.

Signature: _____ **Date:** _____ **Witness:** _____

SIGNATURE NOT OBTAINED:

FIRST ATTEMPT: **Date:** _____ **Time:** _____ **Reason:** _____

Signature: _____ **Date:** _____ **Witness:** _____

SECOND ATTEMPT: **Date:** _____ **Time:** _____ **Reason:** _____

Signature: _____ **Date:** _____ **Witness:** _____