Wesley A. King, M.D.
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Neurological Surgery

AUTHORIZATION, ASSIGNMENT OF BENEFITS AND ACKNOWLEDGMENTS

I hereby authorize payment by my insurance carrier(s) directly to Wesley A. King, M.D., A Medical Corporation and any and all medical associates, for medical services rendered and all major medical benefits.

I understand and agree that I am financially responsible for all charges regarding the servicing of my health care needs regardless of any insurance claims or coverage. Should the insurance carrier fail to pay any portion of my charges, I understand and agree that I will be responsible for the remaining charges and agree to pay the charges in a timely manner. I do hereby waive and fully give up my right to claim that these charges are not collectible by any reason of any applicable statute of limitations or by any applicable bankruptcy filing or defense.

If my account is referred to an attorney for collection or other local action, I agree to pay all reasonable attorney fees and expenses of collection services. I understand and agree that a late charge of 1.5% or $10.00 per month (which ever is greater) will be charges on accounts past due 60 days or more.

I certify that the insurance information contained on the Patient Information Sheet is accurate and correct and that the insurance coverage set forth on such is in effect as of the date of this form.

I authorize Wesley A. King, M.D., A Medical Corporation, to release any information or medical records which are reasonably necessary to process any claim which may have a bearing on benefits payable by any carrier or benefit plan.

I agree that a photocopy of this signed form is as valid as the original and may used in place of the original signed form.

Patient Signature:___________________________________ **Date:**________________

Print Name:____________________________________