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MID-ATLANTIC CARDIOTHORACIC SURGEONS, LTD.

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ADMINISTRATION
DEBRA D. INGE

BILLING MANAGER
KATHY ORRELL

Date: _____

Patient Name: _____ SS#: _____

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL INFORMATION

I authorize MID-ATLANTIC CARDIOTHORACIC SURGEONS, LTD. to obtain any medical information necessary for my treatment and/or to release information needed to process insurance claims for such treatment.

AUTHORIZATION TO ASSIGN BENEFITS

I authorize payment of the medical benefits for services rendered to MID-ATLANTIC CARDIOTHORACIC SURGEONS, LTD.

PAYMENT POLICY

I understand that filing of my insurance by Mid-Atlantic Cardiothoracic Surgeons, Ltd. is done as a courtesy; and that I am financially responsible for any balance remaining. In the event that my account is referred to a collection agency, I agree to pay all costs of collection including the agency's fee of 33 $\frac{1}{3}$ % of the balance owed on referral.

Signature of insured or authorized person _____ Date _____

PLEASE LIST ALL INFORMATION BELOW OR ATTACH A COPY OF YOUR CARD(S)

Name of Company _____

Street Address _____

City _____ State _____ Zip _____

Subscriber _____ Subscriber SS# _____

Insured ID _____ Policy # _____

Group Name _____ Group # _____

Effective Date _____

IF YOU HAVE OTHER INSURANCE POLICIES, PLEASE PROVIDE INFORMATION ON THE REVERSE SIDE OF THIS FORM AND NOTE WHICH POLICY IS PRIMARY.

IF YOU HAVE MEDICARE, DOES YOUR CARD STATE "MEDICAL INSURANCE"? YES / NO

Thank you very much.