PLEASE SIGN AND DATE

I authorize payment of insurance benefits to Dr. Kenneth C. Pair if insurance is filed. I authorize and holder of medical information to be released to the Health Care Financing Administration, its agents, and any information needed to determine the benefits payable to related services.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determined by Medicare as the full payment: However, the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determined by the Medicare agency.

I understand that I am responsible for all services rendered regardless of insurance coverage, and that payment is due at the time of service. I also understand that in case of default I am responsible for all costs of collection to include reasonable attorney's fees.

_____ _____

Signature of Patient or Authorized Representative

Date

PLEASE SIGN AND DATE NEXT PAGE —>