Timothy J. Mickel
M.D., F.A.C.S

Timothy J. Mickel, M.D., F.A.C.S.
903 North 2nd. Street
Monroe, LA 71201
(318) 388-2050

PATIENT AUTHORIZATION

INSURANCE ASSIGNMENT

In consideration of services rendered or to be rendered, I hereby assign and transfer to Timothy J. Mickel, M.D., any benefits payable to or for my benefit under hospitalization or sickness insurance, and any other insurance coverage, to include major medical for the payment of such services rendered. I understand that Dr. Mickel is *NOT* a Network Provider for *ANY* insurance company. I agree to cooperate, aid, and assist Timothy J. Mickel, M.D. in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance may require for payment. This assignment of benefits is irrevocable and extends to the total amount owed to Timothy J. Mickel, M.D. A photocopy of this assignment of benefits is to be considered as valid as the original.

INTIAL: _____

_____ I certify that I have NO insurance which will pay benefits for medical services.

FINANCIAL RESPONSIBILITY

I understand that regardless of my insurance benefits, I AM RESPONSIBLE FOR THE TOTAL CHARGES FOR SERVICES RENDERED, and I further agree that ALL AMOUNTS ARE DUE UPON REQUEST and are payable to Timothy J. Mickel, M.D. I further understand that should this account become delinquent and it becomes necessary for the account to be referred to an attorney or collection agency for collection or suit, I, as the designated responsible party, shall pay the reasonable attorney fees and collection expense.

INTIAL: _____

RELEASE OF INFORMATION

I authorize Timothy J. Mickel, M.D. to release any medical information, including photographs, requested by representatives of local, state or federal agencies, insurance companies, or other organizations or entities as may be required by said representatives for payment of claims arising out of these medical services as are due to Timothy J. Mickel, M.D.

INTIAL: _____

PHOTOGRAPH RELEASE

I authorize the use of all photographs taken of me for any medical purpose deemed appropriate by my physician. I authorize the release of pre- and post-operative photographs to referring physicians.

DATE: _____ _____

RESPONSIBLE PARTY OR PARENT