Nearest Relative not living with you:

Name _____

Address _____

City State Zip _____

Home Phone _____ Cell Phone: _____ Work Phone: _____

Relationship to Patient _____

Authorization For Treatment and Financial Agreement:

I authorize treatment of the person named as patient and agree to pay for all services rendered to patient including but not limited to any amounts not paid by my insurance company. I will be responsible for all copayments, deductibles, coinsurance and /or noncovered services. I request payment of authorized benefits to Dr. Fred Clayson or Dr. Brice Williams on my behalf for any services furnished to me by Dr. Fred Clayson or Dr. Brice Williams I authorize Dr. Fred Clayson or Dr. Brice Williams to release to my insurance company any information needed to determine benefits for my services.

I agree to pay a finance charge of one and one half (1 1/2%) per month on all amounts due and owing to Dr. Fred Clayson or Dr. Brice Willliams. In the event that it becomes necessary to turn over any unpaid balance on my account to a collection agency, I agree to pay up to 33.3% collection expense incurred by Dr. Fred Clayson or Dr Brice Williams. In addition, if legal action should become necessary in order to collect a delinquent amount, I agree to pay reasonable attorney fees or other such costs as the court deems proper.

Signature _____ Date _____