SHOALS UROLOGICAL ASSOCIATES, P.C.

F. LARRY HOLCOMB, M.D.
MARK W. SMITH, M.D.

1015 S. JACKSON HWY.
SHEFFIELD, AL 35660
256-381-5510

2122 HELTON DR.
FLORENCE, AL 35630
256-766-9764

MICHAEL R. YORDY, M.D.
KEVIN M. WALLS, MD

AUTHORIZATION TO GIVE MEDICAL TREATMENT

I hereby authorize SUA to treat this patient as he/she is a minor or does not have mental capability to sign.

PAYING THE BILL

Payment is due at the time service is rendered, unless you have insurance to cover this treatment. You are billed separately for the services of physicians who may aid in the treatment (i.e. radiologist, pathologist, and outside laboratory fees). If any questions arise the office manager here will help you. The telephone number is 381-5510.

INSURANCE

If you have insurance that will cover this treatment and wish us to file you must furnish us insurance claim forms and correct insurance information. BLUE CROSS, MEDICARE, AND MEDICAID must provide us with up-to-date cards. If insurance is incorrectly given we cannot be responsible for filing your insurance.

We expect the bills to be paid within sixty (60) days, therefore you should stay in touch with your insurance company concerning payment of your bill. You will receive statements even though we have filed with your insurance. Your statement will indicate whether or not we have filed.

*************** GUARANTY OF PAYMENT ***************

ACCOUNT NUMBER ____________________ DATE: ________________ 20___

THE undersigned, for value received, promises to pay to the order or Shoals Urological Associated, P.C. on demand, or if not paid sooner, 60 days from date of balanced owed.

________________________ Date ____________

This note is given as guaranty of payment for the value of the services rendered to the person represented by the account number and in the amount shown above. Each and every maker and endorser with recourse hereof agrees to pay all costs of collecting or securing or attempting to collect or secure this note, including a **40% collection fee** for all services rendered in any way in collecting or securing or in attempting to collect or secure the same, whether by suit or otherwise.

PAYABLE AT THE OFFICE OF SHOALS UROLOGICAL ASSOCIATES, P.C. IN SHEFFIELD, ALABAMA.

GUARANTOR'S SIGNATURE ______________________ ADDRESS: ____________________

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Zip Code ______________

Benefits due from insurance will be assigned to the physician with patient responsible for any co-pays, excess charges, deductibles or non-covered services.

I hereby authorize Shoals Urological Associates, P.C., to release to your Company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care.