



MARIETTA PSYCHIATRY ASSOCIATES PC

670 North Ave NW, Suite 200,

Marietta, GA 30060-1100

Phone: 770-678-7034

Fax: 770-678-7035

AUTHORIZATION TO TREAT AND MANAGE PAYMENTS OPERATIONS

I hereby authorize MARIETTA PSYCHIATRY ASSOCIATES PC or any medical provider authorized by it to provide such medical services, either regular or emergency, as may be determined by the medical provider to be in my best interest (or the best interest of my dependent if I am signing as a parent or a guardian). I understand that the treatment may include but is not limited to examination, diagnosis, laboratory tests, diagnostic testing, medical procedures, and administration of medications.

Further, I assign, transfer, and set over to MARIETTA PSYCHIATRY ASSOCIATES PC, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy with the

insurance policy(ies) listed in my record or any other third-party payor that may be responsible for paying me for these services. Should payments be made directly to me, I agree to endorse such payments to MARIETTA PSYCHIATRY ASSOCIATES PC immediately. In those cases where payment is not collected at the time of service, I understand that I am responsible for the cost of medical services rendered and agree to pay all amounts not paid by others within sixty days from the date billed unless there are agreements between me or my insurance company with MARIETTA PSYCHIATRY ASSOCIATES PC. I also agree to pay all collection costs, including, but not limited to, court costs, witness expenses, and reasonable attorney fees if it becomes necessary to turn this account over to an outside party for collection. These authorizations and releases remain in effect until I choose to revoke them by delivering a written statement to MARIETTA PSYCHIATRY ASSOCIATES PC. For Medicare patients with Medigap (or supplemental insurance), I request that authorized Medigap benefits be paid to MARIETTA PSYCHIATRY ASSOCIATES PC for any services furnished to me by that supplier. I authorize any holder of Medical Information about me to release any information needed to determine these benefits to my Medigap insurer. This authorization is in effect until I choose to revoke it