ELIZABETH B WHITE M D
205 HIGHLAND PARK PLAZA
COVINGTON, LA 70433
985-871-8681 FAX 985-871-8684

PATIENT NAME:____

DATE OF BIRTH:________________________________

AUTHORIZATION FOR TREATMENT: THE UNDERSIGNED AUTHORIZES MEDICAL TREATMENT FOR THE PATIENT WHOSE NAME APPEARS ABOVE AND THAT THE TREATMENT AND RELATED PROCEDUERS WILL BE PERFORMED BY PHYSICIANS AND EMPLOYEES OF ELIZABETH B WHITE M.D. AUTHORIZATION IS HEREBY GRANTED FOR SUCH TREATMENT AND PROCEDURES ACKNOWLEDGING THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE RESULTS THAT MAY BE OBTAINED.

ASSIGNMENT OF INSURANCE BENEFITS: I ASSIGN THE BENEFITS OF AND AUTHORIZE PAYMENT DIRECTLY TO ELIZABETH B WHITE M. D. THOSE BENEFITS TO WHICH I AM ENTITLED AND WHICH ARE OTHERWISE PAYABLE TO ME UNDER INSURANCE COMPANIES AND/OR FROM GOVERNMENT AGENCIES. WHILE ANY INSURANCE OR PTHER PROTECTION RELATED TO THE ACCOUNT MAY BE HEREBY ASSIGNED TO AND PAYABLE DIRECTLY TO ELIZABETH B WHITE M.D. THE UNDERSIGNED CLEARLY UNDERSTANDS THAT THE OBLIGATION TO PAY THE BILL IS PRIMARILY ON THE PATIENT AND THE GUARANTOR WHILE INSURANCE PAYMENTS RECEIVED BY ELIZABETH B WHITE M.D. WILL BE APPLIED TO THE PATIENT'S ACCOUNT ANY PART OF THE ACCOUNT NOT PAID BY THE INSURANCE COMPANY OR NOT APPROVED AS MEDICALLY NECESSARY BY AN OUTSIDE REVIEW ORGANIZATION AND/OR PAYOR IS OWING AND PAYABLE BY THE PATIENT OR GUARANTOR.

FINANCIAL AGREEMENT: I AGREE THAT IN CONSIDERATION OF THE SERVICES RENDERED TO THE PATIENT WHOSE NAME APPEARS ABOVE; **I INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OR ELIZABETH B WHITE M.D. IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF ELIZABETH B WHITE M.D.** IN THE CASE OF DEFAULT OF PAYMENT AND IF THE ACCOUNT SHOULD BE PLACED WITH AN ATTORNEY OR COLLECTION AGENCY FOR COLLECTION, I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COURT COST IF APPLICABLE.

I HAVE RECEIVED A COPY OF PATIENT'S RIGHTS AND RESPONSIBILITIES

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SIGNATURE: ____

DATE: _____________________