LINCOLN SURGICAL ASSOCIATES, LTD

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Patient Authorization

I hereby authorize Lincoln Surgical Associates, Ltd. to release to or obtain from my insurance company, any medical facility, or physician involved in my care, information acquired in the course of my treatment. I authorize my insurance company to pay medical benefits for services rendered directly to my Lincoln Surgical Associates, Ltd. surgeon. I understand that I am financially responsible for any and all services rendered, including those which are not covered under the terms of my insurance policy. I also understand that I will pay all reasonable attorney and/or collection fees incurred as a result of collection action for amounts due for any services rendered.

Name: _____ DOB: ____/____/____
Last First Middle Initial Month Day Year

Signature: _____ Today's Date: ____/____/____
(Patient signature - please sign after printing form) Month Day Year