PRACTICE PAYMENT POLICY *** Lifetime Signature on File

I, the undersigned, agree that I am responsible for payment of services given to me by any of the following Practice(s): Southern Surgical Associates, Southern Urology, Hattiesburg Surgery Center or Southern Urology Surgery Center, further referred to as Southern Surgery and Urology Center. If patient is under 18, parent signing this form requesting treatment assumes financial responsibility. Payment in full is due at the time of service unless I am covered by an accepted commercial insurance or government coverage plan. I agree that if this account is not paid when due and the Practices should retain either a collection agency or an attorney for collection, I will pay a collection fee in the sum of 35% of the unpaid debt plus reasonable interest as permitted by law and court cost and attorney's fees incurred in collection of the debt. I agree, by providing above "Practice(s)", with my landline number, cell phone number(s) or email address, I give express authorization to be contacted by Practice(s) agents at those numbers. This includes contacting me by sending text messages or emails, using the phone numbers and email address that I have provided which may result in charges from my cell phone plan carrier. Methods of contact may include using pre-recorded artificial voice messages and/or use of an automatic dialing device, as applicable. I authorize the Physicians and NPs of the Practice(s) and its designees to provide any treatment they consider necessary. I further authorize non-practice labs, radiology centers, third party hosting sites, pathologist and radiologist who may interpret and/or report on diagnostic test and anesthesia provider who may administer anesthesia during a scheduled procedure to provide such treatment if ordered by my Practice(s) provider.

Signature of Patient	Date	Relationship to Pt (if Minor)

INSURANCE - MEDICARE - MEDICAID*Lifetime Signature on File

I, the undersigned, authorize payment of medical benefits to the above Practice(s) for any services rendered to me by the Practice(s). I understand that I am financially responsible for any amount not covered by my insurance policy. I also authorize you to release any information concerning my healthcare to my insurance company. This information will be used for the purpose of evaluation and administering claims and benefits.

Signature of Patient	Date	Relationship to Pt

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have the right to read a copy of Southern Surgery and Urology Center's Notice of Privacy Practices. I can either request a copy of this policy or view it on the clinic's website at www.surgeryandurology.com. I understand that I may address any questions or concerns I may have about the Notice to the Practice's Privacy Officer.

Signature of Patient	Date	Relationship to Pt (if Minor)

HEALTH INFORMATION RELEASE CONSENT - I give permission to share my health information to the following:

NAME	RELATIONSHIP	CONTACT NUMBER

Signature of Patient	Date	Relationship to Pt (if Minor)