AUGUSTA SURGICAL GROUP, P. C.

PLEASE READ AND SIGN BELOW

Your signature below indicates your consent for treatments, and hereby authorizes the release of any information acquired in the course of your examination or treatments to your insurance company.

Signature:_____ Date: _____

I hereby assign, transfer, convey and authorize all payments to the physicians for medical services rendered on my behalf. I understand that I am responsible for any amount not covered by insurance.

Signature:_____Date:_____

Privacy practices acknowledgment: I hereby, acknowledge that Augusta Surgical Group, P.C. will provided me with the notice of its privacy practices as required by the federal health insurance portability and accountability act of 1996 (HIPAA). I understand that Augusta Surgical Group, P.C., upon my request, will provide me with a copy of the notice of privacy practices.

Signature:_____Date:_____

1430 Harper Street, Building B, Augusta, GA 30901 Phone: (706) 724-5451 and Fax: (706) 724-9562