Financial Agreement and Authorization for Treatment:

I authorize treatments of the patient named below and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements, promptly upon presentation thereof, unless credit arrange-ments are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within (30) thirty days of billing date. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release to release all information necessary to secure payment of benefits. I further agree that a photocopy and/or an electronic version of this agreement is as valid as the original.

Life-Time Insurance Authorization:

I authorize and request that payments under my insurance programs be made to Andre C. Matthews, M.D. for any services furnished to patient named below.

Patient Name: ______________________________

Date: ______________________________

Date of Birth: ______________________________

Responsible Person Name: ______________________________

Signature: