ATLANTA RHEUMATOLOGY CONSULTANTS

3193 Howell Mill Road, Suite 317
Atlanta, GA 30327

PATIENT NAME _____ Date _____

I acknowledge that if I do not sign this form, that I will be responsible for the entire balance for this date of service.

I hereby give authorization for medical treatment by "Atlanta Rheumatology Consultants," and I understand that I am fully responsible for payment of services including co-pays and any out-of-pocket expenses and that your office will file to my insurance carrier as a courtesy. I further understand that it does not constitute a contract between the physician and the insurance company. I authorize my insurance carrier to make payment to "Atlanta Rheumatology Consultants" for medical services rendered, if I have not paid the incurred charges.

I hereby authorize the release of my medical records/documentation to my insurance company, physicians, or attorney with whom I have medical or legal services or to process my medical claim.

_____ _____

Patient Signature Date

PLEASE NOTE – WE CANNOT FILE YOUR CLAIM UNLESS SIGNATURE IS PRESENT