BRIAN G. DICKSON, M.D. • SPENCER H. GUINN, M.D. • JEREMY P. SWYMN, M.D.
BRANDON M. BYRD, M.D. • RONALD A. SISMONDO, JR., M.D. • MICHAEL A. HAUGHEY, D.P.M.
1416 E. Matthews, Suite 200 • Jonesboro, AR 72401 • (870) 932-1820

SIGNATURE ON FILE

Patient's Name ______________________________ Chart No.______________________

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment on all Medicare/Medicaid and/or other Health Insurance benefits to be reimbursed directly to Brian G. Dickson, M.D., Spencer H. Guinn, M.D., Jeremy P. Swymn, M.D., Brandon M. Byrd, M.D., Ronald A. Sismondo, Jr., M.D. or Michael A. Haughey, D.P.M. for services received by me or the above named patient on this date and until this authorization is revoked in writing by me. I understand that this authorization also allows for release of medical information required by my designated insurance company or their agent to determine the benefits payable, and that I am responsible for payment of all co-payments or deductibles as determined by my insurance carrier.

Signed ______________________________ Date ______________________
(Insured or Authorized Person)

ASSIGNMENT OF FINANCIAL RESPONSIBILITY

I accept full responsibility for payment of all charges for services received by myself or the above named patient. I understand that payment of these charges are not contingent upon any third party agreements, settlement of a claim, or outstanding litigation.

Signed ______________________________ Date ______________________
(Responsible Party)

AUTHORIZATION TO TREAT A MINOR

I authorize the above named Physician to provide such medical services including surgery, if necessary, as may be determined in the best interest to above name patient of which I am the parent or legal guardian. This authorization is effective this date and until revoked in writing by me.

Signed ______________________________ Date ______________________
(Parent or Legal Guardian)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I would like to receive a copy of any amended Notice of Privacy Practices. Yes No (circle one)

Signed ______________________________ Date ______________________

If not signed by the patient, please indicate relationship: ❑ Parent or guardian of minor patient
❑ Guardian or conservator of an incompetent patient ❑ Beneficiary or personal representative of deceased patient

For Office Use Only:

❑ Signed form received by: ______________________ ❑ Acknowledgment refused

Efforts to obtain: ______________________________

Reasons for refusal: ______________________________