East Mississippi Medical Clinic, PLLC
Razee A. Ahmad M.D.
4711 Poplar Springs Dr
Meridian, Ms
601-485-7777 Phone 601-485-7766 Fax

Authorization For Medical Care

Permission is hereby granted for any treatment , including but not limited to x-rays, laboratory procedures, examinations, injections as may be advisable or necessary by the attending physicians of the above named clinic or by their consulting physicians. I acknowledge that no guarantees have been made to me at to the results of the treatments or examinations in this facility.

The clinic is authorized to furnish for the patients records requested information or excerpts to any medical service, third party payers (billing purposes) and requisite legal, health or social service facility.

I hereby certify that I have read and understand the above authorization and further acknowledge that from this day forward, consent for treatment is given when I enter the clinic requesting healthcare.

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Signature of Patient or Responsible Adult

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Signature of witness

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Relationship of Person Signing for Patient

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Date

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Assignment of Benefits
Medicare/Medicaid or Commercial Insurances

Recipient's Name____

I.D. Number ____

I request that payment of authorized Medicare/Medicaid/Commercial benefits be made on my behalf to East Ms Medical Clinic, PLLC. I authorize any holder or other information about me to be released to the Division of Medicaid or the Flacal Agent any information needed to determine these benefits or the benefits payable to related services. I further agree that if Medicare/Medicaid or any other insurance claim denies payment , I agree, as the undersigned to be personally responsible for payment.

____
Recipient's Signature

____
Date