Michael W. Johnston, M.D.

7 WINDSWEEP COURT PHENIX CITY, ALABAMA 36870 • (334) 297-5555 • WWW.DRJOHNSTONMD.COM

PAYMENT AUTHORIZATION FORM

Patient Name: _____ Date: _____

Assumption of Responsibility: The undersigned agrees, whether he/she signs as the patient or legal guardian, that in consideration of services to be rendered to the patient named above, hereby obligates themselves, assuimes financial responsibility and agrees to pay upon demand to above named provider. All charges for such services and incidentals incurred by said patient. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney fees and collection expenses. Even though insurance may be filed, the undersigned understands that all bills are payable upon presentation and that he/she and not the insurance company is responsible for the payment of all services.

Signature: _____

Authorization of Release of Information: The undersigned hereby authorizes said provider to release sociological and medical information officially acquired in the course of treatment for any referrals needed for my treatment.

Signature: _____

Notification of Appointments: You must notify our office 24 hours prior to your appointment time of any cancellation. In the event that the above signed patient is unable to keep a scheduled appointment, the undersigned agrees to be responsible for a charge of $40.00 for each appointment missed. Any missed appointments will be charged and payable at the time of your next visit.

Signature: _____

Consent for any/all phone numbers: I/We give Dr. Johnston's office permission to contact me on my home/cell phone numbers for the purpose of treatment, insurance, and/or payment.

Signature: _____