Alabama Family Medical Center

Ramesh Peramsetty, M.D.

Sumathi Puttu, M.D.

AUTHORIZATION FOR TREATMENT

The undersigned has been informed of the treatment considered necessary for the patient whose name appears on the bottom and that the treatment and procedures will be performed by the above physician(s), and whomever he/she may designate as assistants. Authorization is hereby granted for such treatment and procedures.

The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained from said treatment(s).

Patient Name: ______________________________ Date: ________________

Patient Signature: ____

Authorized Person (if not the patient): ____________________________________

Signature of Authorized Person: ____

Relationship to Patient: ____________________

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize payment for services provided in the office and the hospital directly to the above physician(s), otherwise payable to me. I understand I am financially responsible for the medical and/or physician charges not covered by this authorization.

Patient Name: ____________________________________ Date: ________________________

Patient Signature: ____

Authorized Person (if not the patient): ____

Signature of Authorized Person: ____

Relationship to Patient: ____________________________________

Alabama Family Medical Center

1718 Veterans Memorial Parkway, Suite C

Tuscaloosa, AL 35404

Phone: (205) 553-1900

Fax: (205) 553-4575

PERMISSION TO RELEASE INFORMATION

If you anticipate the need for anyone else to have access to protected health information about you, please complete the information below.

I (we), the undersigned patient and/or responsible party hereby authorize Alabama Family Medical Center, LLC, its physicians, agents, employees and/or representatives to discuss, or release any or all patient information about me including, but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc. to the person(s) indicated below:

____Spouse Name: ______________________________

____Parent(s) Name: ______________________________

____Children Name: ______________________________

____Other Name: ______________________________

Patient Name: ________________________________ Date: ______________

Patient Signature: ______________________________

Authorized Person (if not patient): ______________________________

Signature of Authorized Person: ______________________________

Relationship to Patient: _________________________

Employee Witness: ______________________________

COMPLETE WELLNESS GROUP

Dr. Ramesh Peramsetty, Dr Janaki Earla
Dr. Amanda Stevens Dr Sumathi Puttu
Dr. Dustin Sheppard Dr William Barton

As your physician, I want to provide you the best care possible. There are however certain routine services necessary for the maintenance of good health that are NOT covered by your insurance contract. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

If you have medical insurance it is important to understand that your actual insurance benefits may differ from the benefits estimated in your Treatment Plan Estimate. Your Treatment Plan Estimate of insurance benefits is based on information provided by your insurance company and by you. It is an estimate and your insurance benefits may be higher or lower than estimated. In all cases you are responsible for amounts not covered by your insurance unless prohibited by law or contractual agreement

I authorize my insurance benefits be paid directly to Complete Wellness Group. I authorize Complete Wellness Group to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

The patient certifies that he/she has read and agreed to the forgoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

______________________________ ______________________________

Patient Name (Please Print) Patient Signature Date

______________________________ ______________________________

CWG Representative (Please Print) Signature/ Date