AUTHORIZATION

General Consent To Treatment:
I agree and consent to the performance of diagnostic and therapeutic procedures deemed necessary by the patient's physician(s). I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or medical treatment.

Release of Information:
I authorize the practice of Viking Medical Group, Inc. and/or the physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse, mental health and HIV status, if applicable) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare, Medicaid (or their various intermediaries), and the insurance company, health maintenance organization, employer, person acting on behalf of a preferred provider arrangement or third party named on the patient information form (or any of their agents or representatives), when such information is requested for treatment, payment, worker's compensation, utilization review, or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this physician's office.

Assignment of Insurance:
I authorize assignment to the physician who has provided services to the patient the insured's rights to penalties and attorney's fees in the event that the insurer fails to timely pay such benefits.

Acknowledgement of Responsibility to Pay For Services:
I understand that the physician will, as a courtesy, file claims with my primary insurance company. However, I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason, are not paid by any secondary party payor unless there is a specific written agreement between the physician and the patient or between the physician and the payer.

Financing
I understand that outstanding balances must be paid in 60 days of receiving the statement. All balances over 60 days will be charged an additional finance fee of $20.00

Medicare Patients:
I request that payment of authorized Medicare benefits be made directly to the physician that is accepting assignment for any services furnished me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

____________________________ DATE

____________________________ PRINT PATIENT'S NAME

____________________________ PATIENT'S SIGNATURE