Authority is granted to Evergreen Family Medicine to render needed treatment. I authorize payment of medical benefits to be assigned to Evergreen Family Medicine for services rendered. I understand that Evergreen Family Medicine participates in electronic health exchanges that allow the exchange of information for the purposes listed in our notice of privacy practices. I further permit a copy of this authorization to be used in place of the original. I agree to the financial policy as listed: NSF checks will be assessed a $35 fee. If it becomes necessary to use a professional collection agency to collect my account, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and court costs and a $50 collection fee.

Signature: _____ Date: _____