



Dr. Alan K. Montgomery
55021 M 51 North
Dowagiac, MI 49047
Phone: 269.782.3476

Medicare _____

Deductible Met Y N

Insurance _____

Deductible Met Y N

I authorize Dr. Montgomery and/or his staff to release any and all information necessary to complete my billing process for me. I understand that I am responsible for any and all charges above and beyond any Medicare or insurance coverage and any charges not covered. This agreement allows Dr. Montgomery and/or his staff to release the necessary information to necessary laboratories to process my order for supplies. This agreement also allows the release of information in the event of referral to another physician. This lifetime agreement will be left in my file for current and future use. I have the right to revoke this consent in writing at any time unless I have already been treated. Dr. Montgomery and/or his staff have the right to refuse treatment if I decline to sign this form.

When placing an order I agree to pay at least 1/2 (half) of my balance and the remainder when picking up my order.

Signature

Date