J. DOUGLAS CUSICK, M.D., F.A.C.S., Inc.
BOARD CERTIFIED
Plastic, Cosmetic, Reconstructive
and Hand Surgery

Authorization for Treatment

I hereby authorize and direct J. Douglas Cusick, M.D., hereinafter referred to as "Medical Provider", with associates or assistants of his choice to perform the procedure(s) and/or examination(s) that their judgment may dictate to be advisable for my well being.

Authorization to Release Medical Information

I do hereby authorize the Medical Provider to furnish my attorney, insurance carrier or other physician I may designate with a full report on my injury and its examination, diagnosis, treatment, progress notes, etc. in regard to the injury.

Assignment of Benefits

In consideration of the Medical Provider treating my injury, I hereby assign to the Medical Provider, such sums as may be due and owing for medical service rendered to me both by reason of this injury or by reason of any other bills that are due the Medical Provider; and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately pay said Medical Provider. I hereby further give lien on my case to said Medical Provider against any and all proceeds of any settlement, judgment or verdict which may be paid to anyone on my behalf as a result of the injury for which I have been treated by the Medical Provider. This lien shall not attach to any attorney's fees.

I fully understand that I am directly and fully responsible to said Medical Provider for all medical bills submitted by him for services rendered to me, and I agree to pay the same, and that this assignment is made solely for the said Medical Provider's additional protection. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover.

This assignment is irrevocable unless: (1) I and the Medical Provider, in writing, terminate this assignment, and (2) Medical Provider is fully paid for all of his services relating to my injury.

I hereby state that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

Patient's Signature:_____ Date:_____

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

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