

Franciscan Skemp

Mayo Health System

Patient Financial Services

To Whom It May Concern:

I, _____ authorize Franciscan Skemp Healthcare

to discuss my medical account with _____.

I understand I am legally and financially responsible for this medical indebtedness and that Franciscan Skemp Healthcare may follow any legal course to collect this indebtedness.

{signature}

Please have your signature notarized then return this to

Patient Financial Services at 700 West Ave South, La Crosse WI 54601. You may have your signature notarized at any FSH Patient Financial Counselor's office or any bank or Credit Union should have a notary public available.

If you would have any questions please feel free to give us a call at (608) 392-9800 or 1-800-603-2500.

Subscribed and sworn to be me
on _____

Notary Public

My commission expires: _____

This agreement is effective for 12 months unless otherwise specified.

Last	_____	First	_____	Clinic Acct	_____	Hosp G L	_____	S	_____	A	_____
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