FINANCIAL INFORMATION

You may receive bills from several different providers for the care rendered to you today: The physician performing the procedure, the Ambulatory Surgery Center (ASC), anesthesia, and a laboratory if specimens are obtained during your procedure.

FINANCIAL AGREEMENT

If you have insurance, we will help you receive maximum benefits by filing for you; however, we will expect payment of co-pays, co-insurance, and deductibles at the time of service. The undersigned individual guarantees prompt payment of all charges if the insurance carrier rejects the claim of any charges related to this account. If charges remain unpaid, it may become necessary to turn the account over to a collection agency.

ASSIGNMENT OF INSURANCE BENEFITS

Medicare/Medicare/Other Insurance

I hereby assign benefits to be paid, on my behalf, to the ASC that renders service to me. I understand and agree to be financially responsible for charges not paid within a reasonable time by insurance or other third party payer. I certify the information given with regard to insurance coverage is correct.

RELEASE OF INFORMATION

I authorize the ASC to release all or part of my medical records when required for the submission of any insurance claims for payment to the Centers for Medicare and Medicaid Services and their agents, my insurance company(s), or to my employer (if this is a worker's compensation claim).
I also authorize reports of my evaluation, treatments, and any follow up evaluations to be sent to or discussed with my referring Doctor, the Doctor requesting the consultation, my family Physician(s), as well as any other healthcare providers, hospitals, or outpatient facilities that I have or will identify to you.
I permit a copy/fax of this form to serve as an original signature of authorization.

DISCLOSURE OF OWNERSHIP

I have been advised of the following:

A physician performing the procedure may have an ownership interest in this facility.

A schedule of typical fees for services provided by this facility is available upon my request. These procedures are
performed at hospitals and other outpatient facilities in this community. I have the right to choose where to receive
services, including a facility where my physician does or does not have an ownership interest. I have chosen to be
treated at this facility.

CERTIFICATION

I have read and fully understand the information in this form. I received this information prior to the date of my surgery via office staff, postal mail, email message, fax or website link.

____ ____________________

Patient Signature Date

____ ____________________

Witness Signature Date

Affix Label Here