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) and the anesthetist. If specimens are obtained during your procedure, you will also receive a bill from the laboratory and the pathologist who interprets the specimen.

FINANCIAL AGREEMENT

If you have insurance, we will help you receive maximum benefits by filing for you; however, we are required to collect payment for 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 the charges remain unpaid, it may become necessary to turn the account over to a collection agency, in which case, the patient will be responsible for both the outstanding charges as well as the collection agency fees.

ASSIGNMENT OF INSURANCE BENEFITS

Medicare / Medicaid / 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 that the information provided 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 of 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, treatment, 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.

RIGHT TO SITE OF SERVICE & FEE SCHEDULE

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.

Patient Signature _____ Date _____