

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Specialty Surgery and Pain Center the benefit to me, but not to exceed the balance of the charges for this period of hospitalization. A photostatic copy of this assignment shall be considered effective and valid as the original. Center employees are not allowed to describe your coverage under Insurance. If you have coverage questions, you are advised to call your Insurance carrier.

AUTHORIZATION: I hereby authorize release of my medical information necessary to process this claim. I authorize the Specialty Surgery and Pain Center to complain to the insurance commissioner for any reason. I further authorize the release of medical information to those healthcare facilities and/or physicians who may be responsible for the patient's follow-up care. I understand that it may be necessary to test the patient's blood while in the Surgery Center to protect against possible transmission of blood borne diseases such as Hepatitis-B or Acquired Immune Deficiency Syndrome (AIDS). If for example, a Surgery Center employee or physician is stuck by a needle while drawing blood or sustains a scalpel injury, I understand and consent that the patient's as well as the employee's or physician's blood will be tested (as appropriate). I further understand the blood will not be routinely tested for these diseases and the results of any testing will be kept confidential in accordance with the state law.

FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to the Specialty Surgery and Pain Center for any amount not covered by this authorization. Within 48 hours, a claim will be filed with my insurance carrier.

NOTE: YOU WILL BE BILLED SEPARATELY FOR SERVICES PROVIDED BY YOUR SURGEON AND/OR ANESTHESIOLOGIST.

Date: _____ Signature: _____ Relationship to Patient: _____
(Parent or Legal Guardian if Patient is a Minor)

PATIENT INFORMATION

.....
DOS NAME (LAST, FIRST, M.I) BIRTHDATE AGE SEX ACCT #

ADDRESS SOCIAL SECURITY NO. MARITAL STATUS

CITY, STATE, ZIP CODE HOME PHONE # WORK PHONE #

EMPLOYER EMERGENCY CONTACT PHONE #

SURGEON REFERRING PHYSICIAN

RESPONSIBLE PARTY

.....
NAME (LAST, FIRST, M.I) RELATIONSHIP TO PATIENT

ADDRESS HOME PHONE # WORK PHONE #

CITY, STATE, ZIP CODE EMPLOYER

PRIMARY INSURANCE

.....
INSURER INSURED'S NAME (LAST, FIRST) PT RELATIONSHIP TO INSURED

INSURED'S ID NO. GROUP NO. GROUP NAME

SECONDARY INSURANCE

.....
INSURER INSURED'S NAME (LAST, FIRST) PT RELATIONSHIP TO INSURED

INSURED'S ID NO. GROUP NO. GROUP NAME