

# Swiss Avenue Surgicenter

# Authorization and Financial Agreement

<b>Patient Information:</b>	Race	Birth date	Age	Sex	Account Number
ROBERT PLOCK		07/26/1968	44Y	M	0101011
Address			City, State, Zip code		
6827 LATTA PARKWAY			DALLAS, TX 75227		
Home Phone			Work Phone		
214-799-7775					
Social Security Number					
456-53-3292					

**RELEASE OF INFORMATION:** I authorize the facility to disclose my protected health information (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers, manufacturers required by FDA to track medical devices, or my employer. This includes appropriate release of and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

**FINANCIAL AGREEMENT:** I hereby certify that the information provided regarding my health insurance coverage is true and correct and I understand that failure to provide this information may result in rejection of this claim. Any unpaid deductible and/or estimated co-insurance or co-pay is due and payable the day of my procedure. I understand that charges not payable by insurance is my responsibility and all charges are due within 90 days from the date of service regardless of any insurance pending.

**ASSIGNMENT OF INSURANCE BENEFITS:** In consideration for the services rendered, or to be rendered, I hereby irrevocably assign and transfer to the facility and to any physician providing services, all rights, title and interest, to the benefits payable by any and all third party payors, including Medicare that are or may be liable for the services rendered to the patient. This irrevocable assignment and transfer shall allow the facility or those physicians to pursue any such right of recovery.

**MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

**HIPAA PRIVACY NOTICE:** I acknowledge that I have received the Facility's HIPAA Privacy Notice and have had the opportunity to review its content. RP (Please initial)

**RIGHTS AND RESPONSIBILITIES:** I acknowledge that I have received a copy of the Patient Rights and Responsibilities. RP (Please initial)

I certify that I have read this document, and am the patient, or am duly authorized to execute it and accept its terms.

Robert Plock 05/29/2013  
Patient Signature Date

\_\_\_\_\_  
Patient/Parent/Guardian/ or Conservator Date

\_\_\_\_\_  
If signed by anyone other than the patient – please indicate relationship