INSURANCE INFORMATION

AF 1001 5/16/11 Rev. 2

INSURANCE AUTHORIZATION: I hereby authorize, SURGICAL ADVANCED SPECIALTY CENTER II, Ltd, LLP. to furnish information to my insurance carrier, concerning my illness and treatment. I hereby authorize SURGICAL ADVANCED SPECIALTY CENTER to appeal claims reimbursement determination on my behalf, as my Designated Representative, and, as part of the appeal. I hereby authorize my insurance carrier in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following: all medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed. I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law.

ASSIGNMENT OF BENEFITS: I hereby assign to SURGICAL ADVANCED SPECIALTY CENTER II, Ltd, LLP. all payments for medical services rendered to myself or my dependents, I understand that I am responsible for any amount not covered by my insurance.

SELF-PAY PATIENTS: I hereby understand that as a self-pay patient, I am responsible for the entire amount due for medical services provided by the physicians at SURGICAL ADVANCED SPECIALTY CENTER II Ltd, LLP. I also understand that I have the option of paying the entire amount due before surgery and in doing so; I may receive a 20% discount.

CONSENT: I voluntarily consent and authorize any surgical, medical, and/or diagnostic procedure planned for me.

MEDICARE PATIENTS: Medicare will pay for services that it determines to be “Reasonable and Necessary” under section 1862(A)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is “not reasonable and necessary” under Medicare program standards, Medicare will deny payments for the service. As your physician, I feel that the service/s being given to you are in your medical interest.

I have been notified by my physician that it is possible, in my case, that Medicare may deny payment. If Medicare denies payment I agree to be personally and fully responsible for payment.

IF INSURANCE IS MEDICARE: MEDICARE#
IF INSURANCE IS MEDICAID: MEDICAID#
IF INSURANCE IS COMMERCIAL: POLICY OR CONTRACT#

Patient’s Name:

Responsible Party Signature:

Signature

__________________________________ __________________________________

Signature of Designated Representative | Title of Designated Representative