Ten Mile Surgery Center

Patient Name
Date of Birth
Physician
Date of Service

RELEASE OF INFORMATION:

In general, medical information concerning the patient's procedure is treated as confidential by Ten Mile Surgery Center, LLC, its personnel and members of its medical staff. I authorize Ten Mile Surgery Center, LLC, to release any information for the purpose of determining coverage to my insurer or other entity responsible to claims payment without my further written consent.

FINANCIAL AGREEMENT & ASSIGNMENT OF INSURANCE BENEFITS:

In consideration for the services rendered to the above named patient, the undersigned hereby individually obligates him/herself to the account of Ten Mile Surgery Center, LLC, in accordance with the Surgery Center regular rates and terms regardless of whether insurance payments are available or made on my behalf. In the event it should be necessary to refer the account to any attorney or collection agency for collection; I hereby agree to pay reasonable attorney's fees and collections expenses. All delinquent accounts, at Ten Mile Surgery Center, LLC, option, bear interest at the legal rate.

In consideration for the services rendered to the above named patient, the undersigned hereby authorizes direct payment of any insurance benefits to Ten Mile Surgery Center, LLC, otherwise payable to me for this admission. I transfer and assign all the right title and interest in the above named insurance policy and payment due to the above named Surgery Center.

I understand and agree that I am responsible for providing any information required by my insurance company and agree to follow those pre admission and pre authorization guidelines which the insurance company may require. I understand that I am financially responsible for all charges which are not covered by insurance, including, but not limited to, co-pays, deductibles, charges in excess of policy coverage, and limitations or exclusions of coverage.

I CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I AM THE PATIENT, PARENT, LEGAL GUARDIAN OR AM DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO THE EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

I UNDERSTAND AND AGREE THAT, AT THE TIME THE PATIENT HAS MET TEN MILE SURGERY CENTER, LLC, MEDICAL CRITERIA TO LEAVE THE FACILITY, I WILL HAVE A RESPONSIBLE ADULT PRESENT TO TAKE ME/PATIENT HOME. I RELEASE TEN MILE SURGERY CENTER, LLC, FROM ANY RESPONSIBILITY FOR EVENTS IN VIOLATION OF THIS AGREEMENT.

Patient Signature Witness Date Time

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