Signature on File, Assignment of Benefits, Financial Agreement

1. **MEDICARE**: I request that payment of authorized Medicare benefits be made on my behalf to Green Valley Surgery Center, for services furnished to me by Green Valley Surgery Center. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If a secondary insurance is listed, my signature authorizes releasing the information to the insurer or agency shown. Green Valley Surgery center accepts the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.
2. **MEDIGAP**: I understand that if a Medigap policy or other health insurance is indicated, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Green Valley Surgery Center, if possible or otherwise to me.
3. **RELEASE OF INFORMATION**: Green Valley Surgery Center may disclose all or part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV to any person or corporation (1) which is or may be liable under contract to Green Valley Surgery Center for reimbursement for services rendered and (2) any health care provider for continued patient care. Green Valley Surgery Center may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, and medical research, for the collection of statistical data or pursuant to State or Federal Law, statute or regulation. A copy of this authorization may be used in place of the original.
4. **OTHER INSURANCE**: I understand that Green Valley Surgery Center maintains a list of health care plans with which it contracts. A list of such plans is available from the business office. And that Green Valley Surgery Center has no contract, expressed or implied with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Green Valley Surgery Center if he/she belongs to a plan that does not appear on the above-mentioned list.
5. **NON-COVERED SERVICES**: I understand that Green Valley Surgery Center’s contracts with health care service plans (i.e. HMOs, PPOs) relate only to items and services which are “covered” by the health care services plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient’s contract with health care service plan or in the benefit summary the health care service plan furnishes to the patient: and treatment or test not authorized by the health care service plan. The undersigned agrees to cooperate with Green Valley Surgery Center to obtain necessary health care service plan authorizations.
6. **FINANCIAL AGREEMENT**: I agree that in return for the services provided to the patient by Green Valley Surgery Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Green Valley Surgery Center for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney’s fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, liable to the patient, is hereby assigned to Green Valley Surgery Center. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Green Valley Surgery Center. However, it is understood that the undersigned and/or patient are primarily responsible for the payment of the patient’s bill.

____ ________________

Beneficiary Name (print) **Medicare Number**

____ ________________

Beneficiary Signature or Authorized Party **Date**

Patient Sticker