Cool Springs Surgery Center

DOS: **ID / Visit: /**

PATIENT INFO:

SEX: **DOB:** **AGE:** **HOME PHONE:**

ADDRESS:

SSN: **DRIVERS LICENSE:** **OCCUPATION:** **PH:**

RESPONSIBLE PARTY:

RSP SSN: **RSP OCC:** **RSP PH:**

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
POLICY: **GROUP:**	**POLICY:** **GROUP:**
AUTH:	**AUTH:**
SUB EMP/PH:	**SUB EMP/PH:**

PERFORMING PHYS: **REFERRING PHYS:**

DIAGNOSIS:

PROCEDURE(S):

RELEASE OF INFORMATION

Cool Springs Surgery Center ("Center") is authorized to furnish information from the patient's medical record to any insurer, compensation carrier, or welfare agency which may be providing financial assistance for Center care. The patient indemnifies the Center and holds it harmless from any and all damage or prejudice which might result to the patient or his/her relatives or heirs from use or misuse by the insurance company of the information turned over to it by the Center pursuant to the patient's written authorization.

STATEMENT TO PERMIT PAYMENT OF OUTPATIENT SURGICAL AND MEDICAL INSURANCE BENEFITS TO Cool Springs Surgery Center:

I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf.

ASSIGNMENT OF INSURANCE BENEFITS:

In consideration for the services rendered to the above named patient, the undersigned hereby authorizes direct payment of any insurance benefits to the Center otherwise payable to me for the admission. I transfer and assign all the right title and interest in the above named insurance company and payment due me to the Center (A photocopy of this form is valid). I hereby authorize the Center, its agents, affiliates and employees to have access to my medical records for the purpose of performing its billing and collection, administrative, financial, and business functions. I further authorize Medicare to furnish medical or other information on this admission required by its intermediary under the Title XVII Program to the extent necessary to process any complementary coverage claim under my agreement in effect with any third party issuer. I assign the benefits payable for facility services to the facility or organization furnishing the services or authorize such facility or organization to submit a claim to Medicare for payment to me.

FINANCIAL RESPONSIBILITY:

In consideration for the services rendered to the above named patient, the undersigned hereby individually obligates him/her to the account of the Center in the 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 neccesary to refer the account to any attorney or collection agency for collection; I hereby agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts at the Center bear interest at the legal rate. I understand and agree that I am responsible for providing any information required by my insurance 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 execute the above and accept its terms.

By signing below, I consent to be contacted by regular mail, by email, or on my cell phone regarding any matter related to the above referenced by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes phone calls that employs auto-dialer technology and prerecorded messages. This consent applies to all healthcare providers covered under this agreement. If I wish to revoke consent to call my cell phone, I agree to provide you notice of that revocation by certification mailing it to: 2009 Mallory Lane, Suite 100 Franklin, TN 37067.

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 EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

I UNDERSTAND AND AGREE THAT, AT THE TIME THE PATIENT HAS MET Cool Springs Surgery Center MEDICAL CRITERIA TO LEAVE THE FACILITY, I WILL HAVE A RESPONSIBLE ADULT PRESENT TO TAKE ME/PATIENT HOME. I RELEASE Cool Springs Surgery Center FROM ANY RESPONSIBILITY FOR EVENT IN VIOLATION OF THIS AGREEMENT.

Signed	**Witness**	**Date**	**Time**