SurgiCare of Manhattan, LLC

GENERAL CONSENT and ASSIGNMENT OF BENEFITS

Patient Label

I, _____hereby request, and consent to examination and treatment (including laboratory, diagnostic and medical/surgical procedures) rendered by Dr. _____ his/her assistants and designees. I also consent to the disposal of specimens taken by laboratory or pathology examination.

In advance of the date of my scheduled procedure at SurgiCare of Manhattan, LLC
I have received the following information:

A. Disclosure of Financial Interest in SurgiCare of Manhattan, LLC
B. Patients Rights
C. Advance Directives

My signature below denotes I have received a copy of this office's Notice of Privacy Practices.

All patient must complete our Patient Information Sheet before having his/her procedure.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, No Fault, and any other health/medical plan, to issue payment check(s) directly to Surgery Center, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Financial Responsibility

I have requested medical services from the facility on behalf of myself and for my dependents and understand that by making their request I become fully financially responsible for any and all charges incurred in the course of treatment. We accept cash, check or money order, Visa or MasterCard. There is a $25 fee for any returned check. A payment plan can be arranged if needed – just contact our billing office at 201-834-1120.

Regarding Managed Care Insurance We Participate With

You are responsible to supply our staff with your ID cards. We will automatically file the claim for you. However, you are responsible for any deductible coinsurance or co-pay due at the time of service as described in your insurance handbook. If any of the procedures performed here are not a covered item under your plan, you will be financially responsible for payment in full.

Regarding Non-Participating Insurance

It is your responsibility to understand which insurance plans the Surgery Center participates with. The bill is your responsibility and is due at the time of service. Your insurance policy is a contract between you and your insurance company. Our center is not a part of that contract. We are happy to file your claim directly with your insurance company. However, the ultimate responsibility for payment remains yours. Since Surgery Center does not participate with your insurance carrier you may receive the payment for services rendered. Please forward payment along with the explanation of benefits directly to us within 5 business days.

Regarding Medicare and Supplementary Insurance

We will automatically file your claim directly with Medicare and any other supplementary insurance if applicable. However, you remain responsible for your yearly deductible as well as any remaining co-payment. You will also be asked to sign an ABN Waiver as required by Medicare for services that may not be deemed a covered service.

Regarding Pathology and Laboratories

It is your responsibility to understand which laboratory your insurance company affiliates with. Fees are billed separately. Our center will not be held liable for any services rendered to you by a non-participating laboratory.

Patient Label

Regarding Anesthesia
Anesthesia fees will be billed separately.

Authorization to Release Information
I hereby authorize SurgiCare of Manhattan, LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment, and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from Surgery Center on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.
I acknowledge and agree that, if I receive any check payment from my insurance carrier in connection with obtaining "out-of-network" services at the Facility, I will endorse and assign the check to Surgery Center and immediately forward it to Surgery Center within five (5) days of receipt of the check.

I have read the above Consent and Policy; I agree and understand its terms:

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

_____ _____
SIGNATURE OF WITNESS DATE

FORM SSA-consent (08/11)