HIPAA Consent, Insurance and Financial Authorizations

Assignment of Insurance Benefit:
I hereby authorize payment directly to West Michigan Surgery Center the benefits payable to me, but not to exceed the balance of the charges for this event. All co-pays and deductibles are due prior to or at the time of treatment.

Financial Responsibility:
I understand I am financially responsible to West Michigan Surgery Center for any amount not covered by my insurance. The insurance policy is a contract between myself and my insurance company. A claim (bill) will be filed with my insurance carrier within 45 days. If payment is not made by the insurance carrier within 45 days of the filing, the balance will automatically transfer to the responsible party account. Payment by responsible party is expected within 10 business days of notice of insurance non-payment. In the event that this account is placed with an attorney or collection agency, the undersigned is responsible for collection fees, reasonable attorney's fees and court costs.

Authorization:
I hereby authorize the release of my medical record information necessary to process insurance claims. I authorize West Michigan Surgery Center to issue a complaint to the insurance commissioner for any reason. I further recognize the release of medical information to those healthcare facilities and/or physicians who may be responsible for the patient's care. Services provided by your surgeon, anesthesiologist, pathologist or other services will be billed separately.

Receipt of Privacy Notice:
I hereby consent to the surgery center's use and disclosure of my individually identifiable health information for the purposes relating to my treatment, the payment of my healthcare and other healthcare operations of the surgery center. In addition, I acknowledge that I received on the date indicated below a copy of the West Michigan Surgery Center's Notice of Privacy Practices, which describes the obligations of the surgery center regarding its use and disclosure of my individually identifiable health information and my rights regarding this information. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations and that the surgery center is not required to agree to the restrictions requested.

I request the following restrictions to the use or disclosure of my health information:
_____

Ownership Disclosure
West Michigan Surgery Center is an ambulatory surgery center owned and operated by Girish Juneja, MD.

Responsible Drivers Name: _____ Contact Phone: _____

_____ _____
Signature of Patient or Legally Authorized Representative

Printed Name of Legally Authorized Representative
Relationship: □ Spouse □ Legal Guardian □ DPOA for Healthcare

Date _____