AGREEMENT OF RESPONSIBILITY

STATEMENT TO PERMIT PAYMENT OF OUTPATIENT SURGICAL AND MEDICAL INSURANCE BENEFITS TO *Woodcrest Surgery Center.*

I certify that 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

I authorize payment directly to ***Woodcrest Surgery Center*** for covered outpatient benefits otherwise payable to me to include major medical benefits. (A photocopy of this form is valid)

RELEASE OF INFORMATION

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

I hereby authorize ***Woodcrest Surgery 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 (Missouri Medicare Services, PO BOX 66505, St. Louis, Missouri) 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 of the rendering of service to the patient the undersigned guarantees the payment of any amount due for such services rendered by the ***Woodcrest Surgery Center*** over an above the amount covered or not paid by any third party payer(s) insurance based on payer provisions.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice. _____ Patient Initials

_____ _____ _____

Patient's Signature **Date** **Witness Signature**

_____ _____

Legal Guardian's or Power of Attorney Relationship to Patient

ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

PAYMENT GUARANTEE

The undersigned severally agree, whether signing as a patient or otherwise, that in consideration of the services rendered accordance with the regular rates and terms of the anesthesia provider listed below. The undersigned clearly understands that the obligation to pay the account is primarily on the patient and the undersigned and while insurance payments received will be applied properly to the patient's account, any part of the account not so paid by the insurance is nevertheless owing and payable. I we further agree to pay all court and/or reasonable attorney's fees incurred by the Anesthesia provider in enforcing their payment.

AUTHORIZATION TO RELEASE INFORMATION

I consent and agree to authorize the provider of Anesthesia services provided by **JOSEPH A. BENDET ANESTHESIA, LLC** to release and disclose any personal and medical information the insurance companies. I also release the provider from all legal liability that may arise from the release of information. I understand that this information is to be released and disclosed only for the purpose of determining the amount payable for all services rendered.

ASSIGNMENT OF ANESTHESIA INSURANCE BENEFITS AND FINANCIAL AGREEMENT.

Extended payment request (one time authorization): I hereby authorize payment directly to **JOSEPH A. BENDET ANESTHESIA, LLC** for the anesthesia benefits, otherwise payable to be but not to exceed the anesthesiology regular charges for this period of inpatient/outpatient anesthesia consultation fee and for any other period of consultation.

MEDICARE ADVANCE NOTICE: In some instances Medicare does not consider anesthesia services "reasonable and necessary" under section 1862(a) (1) of the Medicare law. If Medicare determines that your particular service, although would otherwise be covered, is not "reasonable and necessary" under Medicare standards, Medicare will deny payment for that service. In instances where Medicare denies payment for any anesthesia service rendered, I agree to be personally and fully responsible for payment.

_____ _____

Patient / Responsible Party Signature Date