PREMIER OUTPATIENT SURGERY CENTER

DEMOGRAPHICS AND FINANCIAL AGREEMENT

Last Name	First Name	M.I.	Social Security Number	Date

M/F	DOB	Patient Home Phone #	Patient Cell Phone #	Patient Email

Patient Address	Street	City	County	State	Zip

Patient's Employer / ☐ Retired / ☐ Not Employed	Employer City	Work#	Date of W/C injury

Primary Ins. Co. Name	Secondary Ins. Co. Name
Name of Subscriber	**Name of Subscriber**

I.D.# / SSN	Subscriber DOB	Circle One: M / F	I.D.# / SSN	DOB	Circle One: M / F

Minor ☐ Yes	Responsible Party Name & Address	Relation to Patient	Phone

ESTIMATED COINSURANCE

Patient's estimated discounted coinsurance/cash price is _____. This estimate is based on the information received from the Patient's insurance company and doctor's office and is payable at the time of service. Any amount of the coinsurance/cash price not paid at the time of service is not eligible for a discount. Patient's final coinsurance amount may differ from the estimated coinsurance listed above and is calculated based on the actual procedure performed by the physician(s). It is my responsibility to notify Premier Outpatient Surgery Center of any changes in my health care coverage. I understand that exact charges and insurance benefits cannot be determined until the services have been rendered and the insurance company processes my claim.

ASSIGNMENT OF BENEFITS

I am the above named insured with the Insurance Company(s) listed above. I hereby authorize any benefits due to me under my insurance policy(s) to be paid according to this Assignment. I assign, transfer and request that any insurance payment related to the service(s) that I or my dependent _____ receive(s) today is to be paid directly to the provider of service, be it facility, physician, anesthesiologist, hospital, pathologist and/or other supplier. A photostatic copy of this assignment shall be considered effective and valid as the original.

FINANCIAL AGREEMENT

I INDIVIDUALLY AGREE TO PAY THE ACCOUNT OF PREMIER OUTPATIENT SURGERY CENTER IN ACCORDANCE WITH ITS REGULAR RATES AND TERMS as consideration for the services rendered to me. I authorize direct payment of any insurance benefits to PREMIER OUTPATIENT SURGERY CENTER that are otherwise payable to me for this admission at a rate not to exceed PREMIER OUTPATIENT SURGERY CENTER'S regular charges. Should my account be referred to an attorney or collection agency for collection, I agree to pay all reasonable attorney's fees and collection expenses. All delinquent accounts (those not paid within 60 days) shall accrue interest at the legal rate. I understand that I am financially responsible for any charges not covered by my Insurance Company(s). I understand that, as a courtesy, the PREMIER OUTPATIENT SURGERY CENTER will file a claim with my primary Insurance Company. After 60 days from the date of surgery the total balances will be considered due and payable.

CONSENT TO RELEASE CLAIMS INFORMATION

I hereby consent for Premier Outpatient Surgery Center (POSC), their employees and agents to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the purpose of treatment, health care operations evaluating claims for payment or reimbursement for charges and expensed under any public Title XVIII of the Social Security Act (Medicare), or any private reimbursement which may have a bearing on behalf in completing claims. I (or patient) may restrict the uses of information with written notice and if agreed to by POSC the additional limitations are binding.

I have read and understand the above release _____ (Initials)

I understand that the PREMIER OUTPATIENT SURGERY CENTER shall have the right at any time to refuse to admit me or my dependent(s) or to provide medical care or treatment for me or my dependent(s). I authorize the release of any medical or other information needed to provide services to me and to determine benefits for all services rendered.

I certify that I am the patient or am duly authorized by the patient as patient's general agent to execute this document and accept its terms.

Signed:	Date:	Witness: