



AGREEMENT OF RESPONSIBILITY

STATEMENT TO PERMIT PAYMENT OF OUTPATIENT SURGICAL AND MEDICAL INSURANCE BENEFITS TO MIAMI SURGICAL 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 Miami Surgical 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 Miami Surgical Center. (A photocopy of this form is valid)

RELEASE OF INFORMATION

The Miami Surgical 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 Miami Surgical Center care. The patient indemnifies the Miami Surgical Center and holds it harmless from any and all damages 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 Miami Surgical Center pursuant to the patient's written authorization.

I hereby authorize Miami Surgical 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 Miami Surgical Center in 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 necessary 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 Miami Surgical Center option 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.

Patient's Signature

_____/_____
Date / Time

Witness Signature

Legal Guardian's or Power of Attorney

Relationship to Patient

Policy Holder's Signature