Signature on File, Assignment of Benefits, Financial Agreement

A copy of this form may be used in place of the original

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Patient Name (*please print*)

1. **MEDICARE**: I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made on my behalf to Surgical Center of Greater Annapolis, Inc. (hereafter referred to as 'SCGA') for services furnished me by them. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature on this form requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing that information to the insurer or agency shown. SCGA accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.
2. **MEDIGAP**: I understand that if a Medigap policy or other health insurance is indicated on the CMS-1500 for or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to SCGA if possible, or otherwise to me.
3. **RELEASE OF INFORMATION**: SCGA may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV to (1) any person or corporation which is or may be liable or under contract to SCGA for reimbursement for services rendered, and (2) any health care provider for continued patient care. Unless I give written instructions to the contrary. SCGA may disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original. Our complete written privacy policy is available upon request.
4. **OTHER INSURANCE**: I understand that SCGA maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. I understand that SCGA has no contract, expressed or implied, with any plan that does not appear on the list. I agree that I am individually obligated to pay the full charges of all services rendered to me by SCGA if I do not belong to a plan on the above-mentioned list.
5. **NON-COVERED SERVICES**: I understand that SCGA contracts with health care service plans for items and services that are covered by those health care service plans. Accordingly, I accept full financial responsibility for all items or services, that are determined by those health care service plans not to be covered. Examples of non-covered services include but are not limited to the following: (1) services not specified as being covered in the patient contract with the health care service plan or in the benefit summary the health care service plan furnishes to the patient (2) any service, treatment or test not authorized by the health care service plan. The undersigned agrees to cooperate with SCGA to obtain necessary health care service plan authorizations.
6. **FINANCIAL AGREEMENT**: I agree that in return for the services provided to me by SCGA. I will pay my account at the time service is rendered or will make financial arrangements satisfactory to SCGA for payment. I understand that SCGA maintains a separate and legal policy concerning overdue balances. This policy in full is available from the billing office. If an account is sent to an attorney or other collection agent, then I agree to pay collection expenses and reasonable attorney fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, then I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to SCGA. If co-payments and/or deductibles are designated by my insurance company or health plan, then I agree to pay them to SCGA.
7. **NO SURPRISES ACT:** The Surgical Center of Greater Annapolis is compliant with the No Surprises Act. Protecting patients from receiving surprise medical bills. SCGA does not balance bill for out of network procedures and will provide a good faith estimate for uninsured patients upon request.
8. _____ (initial) **I understand it is my responsibility to provide SCGA accurate insurance information. If the insurance information is inaccurate, I understand I will be personally responsible for payment in full for services rendered by SCGA.**
9. _____ (initial) **I understand that I will be personally responsible for payment in full for services rendered by SCGA when I have not obtained the required insurance referral or pre-authorization. I also understand it is my responsibility as the patient / policy holder to contact my insurance company to determine my specific need for referrals and pre-authorizations.**
10. _____ (initial) **I understand that there may be separate out of pocket expense for the facility, the surgeon, and anesthesia services.**
11. _____ (initial) **I understand that it is ultimately my responsibility as the patient / policy holder to contact my insurance company to determine any out-of-pocket expenses, including but not limited to co-pay, co-insurance, and/or plan deductible.**
12. _____ (initial) **I understand the final out of pocket expense is determined by my insurance upon processing of the claim for services rendered. Any quotation of benefits by SCGA, or my surgeon is not a guarantee of payment by my insurance.**

I understand that this agreement will be effective for one year and applies to any and all procedures performed at the Surgical Center of Greater Annapolis, Inc. within one year of the date below.

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Signature of Patient or Authorized Party Date