

Assignment of Insurance Benefits

Name: _____

I know that I have a health problem that requires diagnosis and/or treatment or surgery. Therefore, I voluntarily consent to my admission and treatment at the Massachusetts Avenue Surgery Center and I authorized the release of any medical information to process insurance claims related to this admission.

I am aware that my physician likely has ownership interest in the Massachusetts Avenue Surgery Center. If I chose to go to another health care facility for this procedure, it will not adversely affect my relationship with my surgeon. I may obtain a complete list of owners from the reception desk.

For purposes of quality and peer review, I authorize Massachusetts Avenue Surgery Center to allow its' representative to review my surgical chart and associated documents.

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I hereby authorize payment directly to Massachusetts Avenue Surgery Center of the health insurance benefits otherwise payable to me during this or any future visit to the Center. I acknowledge that I can reverse this authorization at any time. Within 24 hours, a claim will be filed with your health insurance carrier. You will be notified when final action (payment, denial, etc.) has been received.

I have read and understand the terms of the above statement.

Patient or Authorized Signature (First Visit)

Date

Patient or Authorized Signature (Second Visit)

Date

Patient or Authorized Signature (Third Visit)

Date

Relationship