Castle Hills Surgicare Disclosure Form

(Copy for the patient)

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's charges, the Center is authorized to submit a claim for payment to my insurance carrier. The Center is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of deductibles, co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service. **Castle Hills Surgicare is not authorized to transfer any patient/overpayment to your physician/ anesthesia providers/ and/or pathology, if an outstanding balance exists.** I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company, as applicable by state and/or federal law. I understand that without my signature, my insurance cannot be filed nor, can any reports be released to my referring physician.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Castle Hills Surgicare, my admitting Physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balance due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physician who render service to charges not paid for within a reasonable period of time by insurance or third-party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician, or other physicians who render service to release all or part of my medical records where required by or permitted by laws or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that Dr. Adnan Nadir, Dr. Syed Hasan, Dr. Erick Anderson, and Dr. John Broadnax have an ownership interest in Castle Hills Surgicare. I understand that I have the freedom to choose to obtain medical services elsewhere and that I should contact my treating physician if I have any questions regarding this ownership interest and/or to discuss availability of alternative treatment facilities. I wish to have my procedure/services performed at Castle Hills Surgicare.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

PATIENT RIGHTS / NOTICE OF PRIVACY PRACTICES / ADVANCE DIRECTIVES INFORMATION

I have reviewed my Patient Rights/Notice of Privacy Practices/Advance Directives. I have been offered a copy for my own records. Please note that Advance Directives are not honored at this facility.

NON-DISCRIMINATION POLICY AND LIMITED ENGLISH PROFICIENCY (LEP) NOTICE:

I have reviewed the Non-Discrimination policy and limited English Proficiency (LEP) notice.

By signing the ASC Conditions for Coverage Patient Attestation, the individual certifies that he/she has read and understands the foregoing and fully accepts all terms specified above. The individual certifies that he/she has read, understands, and has received a copy of their ***Rights and Protections Against Surprise Medical Bills.***