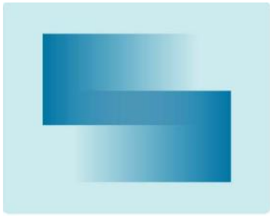

CAPITOLA SURGERY CENTER

ASSIGNMENT OF INSURANCE BENEFITS (INCLUDING MEDICARE BENEFITS) STATEMENT

It is your responsibility to assure that we have the most current and accurate insurance information so that we may bill your insurance carrier.

As a courtesy we will bill your insurance carrier by filing your claim and collecting any deductible, co-insurance and/or co-pay at the time of service.

- I request that payment of authorized benefits be made to Capitola Surgery Center for any services furnished to me by that facility.
- I authorize any holder of medical information about me to be released to the authorized representatives of my insurance carrier as needed to determine benefits payable for related services.
- I understand my signature requests that payment be made to the provider and authorizes the release of medical information necessary to pay the claim.
- I understand if I have more than one insurance carrier, my signature authorizes release of information to the insurer or agency shown for all claims, whether they are submitted electronically or by an approved claim form.
- I understand that I am responsible for payment of any deductibles, co- insurance, co-payments and charges for **non-covered services**, including any service determined to be **"Not Medically Necessary"** or **pre-existing** for services described on the consent form provided on my behalf.

Authorization to Release Medical Records to CSC

I hereby authorize Capitola Surgery Center to release any and all medical records/information acquired in the course of my examination or treatment.

______________________________ ________________________

Signature Date

2265 41ST Avenue, Capitola, CA 95010 I T: 831-462-2252 I F: 831-462-2288