Patient Name: _____ Date of Birth:_____

Date of Surgery:_____ Medical Record #: _____

Financial Agreement

If you have insurance, we will help you receive the maximum benefits by filing your insurance claim for you. However, we will expect payment of all copays, coinsurance, and deductibles at the time of service.

Assignment of Insurance Benefits

COMMERCIAL INSSURANCE:	MEDICARE
I hereby AUTHORIZE the release of any medical information necessary to process my insurance Claims. I AUTHORIZE and request payment of medical benefits directly to my physician(s) at Beverly Oaks Physicians Surgical Center, LLC. I AGREE that authorization will cover all medical services rendered until such authorization is revoked my me. I AGREE that a photocopy of this form may be used in place of the original. Date: _____ Signature: _____	I hereby certify that the information provided by me in applying for payment is true and correct. I hereby AUTHORIZE any holder of medical or other information about me to release it to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I ACKNOWLEDGE and UNDERSTAND that it is mandatory to notify the healthcare provider of any other party who may be responsible for payment of my treatment. Regulations pertaining to Medicare assignment of benefits also apply. Date: _____ Signature: _____

RELEASE OF INFORMATION: I hereby agree that Beverly Oaks Physicians Surgical Center, LLC may disclose my "protected health information" (PHI) in compliance with HIPPA Privacy Provisions which may include my medical records, to any third party payers, including, but not limited to, health insurers, healthcare service plans, state and federal agencies, workers compensation carriers, manufacturers required by the FDA to track medical devices, and/or my employer. This includes appropriate release of and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other healthcare providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has my permission to disclose pertinent information to my family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

DISCLOSURE OF OWNERSHIP: I have been informed that the physician who has referred me and/or who is rendering services to me may have an ownership interest with Beverly Oaks Physicians Surgical Center, LLC, located at 4019 Van Nuys Boulevard, Suite 308, Sherman Oaks, California 91403. I have been given the option to be treated at another facility, which I have declined. I wish to be treated at Beverly Oaks Physicians Surgical Center, LLC.

_____
Initials

I certify that I have read and understand this document, am the patient or am duly authorized to execute it and accept its terms.

Signed: _____ Date: _____
Patient or Patient's Responsible Party

Printed: _____
Patient or Patient's Responsible Party