Valley Surgical Specialists Medical Group Consent and Release Form

Patient Name: _____ DOB:_____ Account Number: _____

By initialing each point and signing below the patient is acknowledging that they have read, understand, and agree to the terms of Valley Surgical Specialists Medical Group's (hereafter referred to as VSS) financial and HIPAA policies and procedures.

1. I hereby authorize the release of information regarding my medical treatment, care, and charges as may be required to complete all claims for benefits. I also authorize my insurance benefits to be paid directly to VSS.

Initial

2. I understand that I am financially responsible for all co-payment, deductibles, and co-insurance, as well as any services not covered by my insurance, including but not limited to denials for:
    a. Non-covered Services
    b. Non-plan Benefits
    c. Non-participating insurance plans/groups
    d. Services deemed as experimental/investigational for any reason
    e. Limits on screening/preventative services

Initial

3. I understand that VSS has reserved the right to require payment of co-pays, deductibles, and co-insurance at the time of service, and acknowledge that I have received a copy of the VSS office financial policy.

Initial

4. I understand that if my insurance requires a referral for specialist's services or authorization for surgical services, that it is my responsibility as a patient to inform VSS regarding limitations on referrals and authorizations, and to verify that referrals have been issued by the physician referring me to VSS, and to verify authorization of surgical services with my insurance company. I also acknowledge that VSS will not be responsible for charges incurred for any referral/authorization not received. I also understand that per insurance rulings, receipt of a referral/authorization is never a guarantee of payment.

Initial

5. I authorize VSS to release my medical record to other physicians as necessary to facilitate my continued care, and further authorize VSS to request and receive records from my other physicians as necessary for my care.

Initial

6. **Medicare Authorization Statement and Claims Submission**
    a. I request that payment of authorized Medicare benefits be made on my behalf to VSS for any services furnished by the physician/supplier. I authorize any holder of medical information about me to release to the health care to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

Initial

Patient Signature: _____ Date: _____