NORTH SPRINGS SURGICAL ASSOCIATES. P.C.

PATIENT RESPONSIBILITES:

We do everything possible to obtain authorization for your medical care including surgery, procedures and diagnostic tests, however**, your insurance policy is a contract between you and your carrier.** As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, coinsurance and/or copays. Benefits, coverage rules and policies differ among insurers and even between different plans of the same insurer.

It is the patient's responsibility to make sure both your physician and facility (hospital, surgery center, imaging facility) are listed as participating providers by your insurance company. It is possible that only the physician or only the hospital/surgery center or only the imaging facility participates with your insurance plan. The patient should also check if the services being rendered are a covered benefit. Not all services are covered in all insurance contracts.

While you may have insurance coverage to pay your medical bills, you are ultimately responsible for all charges. To find out what your insurance plan covers and what your financial obligation may be, call the customer service or member services department of your insurance company (the phone numbers are on your insurance card).

SIGNATURE:_____DATE:_____

COMMUNICATION CONSENT:

A. I DO CONSENT TO LEAVE DETAILED MESSAGES AND/OR DISCUSSION:

I give North Springs Surgical Associates, P.C. and their Staff permission to leave detailed phone messages on or to discuss my medical care with the following: This consent will remain in effect until rescinded in writing.

Home phone voice mail #_____Spouse's name:_____

Cell phone voice mail #_____Other (name):_____

Work Phone voice mail #_____

SIGNATURE:_____DATE:_____

B. I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:

I wish to be contacted personally and do not authorize North Springs Surgical Associates, P.C. and the Staff to leave detailed phone messages or conduct discussions regarding my medical care with anyone or than myself.

SIGNATURE:_____ DATE:_____