PATIENT NAME:_____ **BIRTHDATE:**_____

PATIENT BILLING CORRESPONDENCE

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I hereby authorize Houser Newman Associates to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amounts not covered by insurance.

Date:_____ Signature:_____

PLEASE READ AND SIGN IF COVERED BY MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Houser Newman Associates for any service furnished to me by that physician(s) or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Date:_____ Signature:_____

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of HOUSER NEWMAN ASSOCIATES, MAHONING VALLEY AMBULATORY SURGERY CENTER, and LEHIGH ANESTHESIA ASSOCIATES **Notice of Privacy Policies**. My information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I will allow the following persons to receive my personal medical information:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

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. Regulations pertaining to medical assignment of benefit apply.

Patient Name:_____ DOB:_____

Patient Signature: _____ Date: _____

If not signed by the patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

If patient or patient's representative refuses to sign acknowledgement of receipt notice, please document the date and time the notice was presented to patient and sign below.

Presented on: _____ By: _____

(date/time) (name/title)