Optima Surgery Center

Patient Name: Test Patient Name
Surgeon:
Date of Service
Medical Record:
Date of Birth:

ASSIGNMENT OF BENEFITS - CENTER

I hereby authorize my Insurance Company to pay by check made payable and mailed directly to:

Optima Surgery Center
1500 S. Central Avenue Suite 126
Glendale, CA 91204

for the medical and surgical benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, Optima Surgery Center will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance payment. If my insurance company sends me/partner any checks for services provided at the Center, I will immediately bring or mail the check to Optima Surgery Center. I will endorse the check and annotate "Pay to the Order of Optima Surgery Center " or deposit the check, then send a personal or cashiers check. If it is necessary to file a formal collection action, I agree to pay all costs incurred by the outpatient center in the collection of the outstanding fees. Actual Plan Benefits cannot be determined until the claim is received by your insurance company and is based on their determination of medical necessity. The information received from the above stated is not a guarantee of payment. I agree that I am responsible for annual deductibles or services not covered by my insurance company(s), regardless of whether my insurance is Medicare, Private or HMO. Physician, Laboratory and Pathology services are billed separately from the Center. Cash patients are required to pay the Center at the time of service.

X _____

Patient Signature or Financially Responsible Party | Relationship to patient if not patient | Date

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read, or have had the opportunity to read, this Notice and I understand the Notice.

X _____ _____

Patient's or Authorized Representative's Signature | Date

_____ _____ _____

Authorized Representative (Please print if applicable) | Relationship to Patient | Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check ALL that apply):

☐ Home telephone: _____ Written Communication

☐ OK to speak to :_____

☐ OK to leave message with detailed information ☐ OK to mail to my home address

☐ Leave message with call back number only ☐ OK to mail my work/office address

☐ Work telephone: _____ ☐ OK to fax to _____

☐ OK to leave message with detailed information

☐ Leave message with call back number only ☐ Other