

FINANCIAL RESPONSIBILITY

All charges are due at the time of service. If hospitalization or surgery is indicated PSA will file your claim directly to your insurance company. Please remember that most insurance companies do not pay the full amount, and therefore you are responsible for the balance. If there is a problem paying your balance in full, please let us know and we will establish a payment arrangement with you. For certain elective procedures we require payment in full before providing service. I understand that if I have not secured the appropriate referrals and authorizations and otherwise followed the terms of my health plan contract, there will be a decrease in my insurance coverage or no coverage at all for some or all of the services which I will receive. Therefore, I will be financially responsible for all remaining balances, including co-payments and coinsurance. If I have no insurance, I understand that I am financially responsible for all services provided.

Patient's Signature _____

Date _____

INSURANCE AUTHORIZATION AND RELEASE

I request that payment of authorized benefits – including Medicare, TennCare and any other government sponsored program, private insurance and any other health benefit plans – be made directly to Premier Surgical Associates (PSA) for any services furnished by them. I authorize any holder of medical information about me to release my medical information to those persons or companies presenting a legitimate request for such information needed to determine benefits or the benefits payable for related services. I authorize PSA to act as my agent to help me obtain any required precertification as well as acting as my agent to help me obtain payment from my health benefit plans. I authorize my insurance companies to give PSA any information they require to fulfill this function for me. This authorization will remain in effect until revoked by me in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Patient's Signature _____

Date _____

MEDICARE BENEFICIARIES MEDICARE SUPPLEMENT POLICIES ONLY MEDIGAP ASSIGNMENT AND RELEASE

I request that payment of authorized Medigap benefits be made on my behalf to Premier Surgical Associates, PLLC for services furnished to me by them. I authorize any holder of medical information about me to release to

Name of Policy

any information needed to determine these benefits or the benefits payable for related services. This authorization will remain in effect until revoked by me, in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Patient's Name

Medicare Number

Medigap Policy Name

Medigap Policy Number

Patient's Signature _____

Date _____

NON-COVERED OR NON-AUTHORIZED SERVICES (Referral Wavier)

By signing this form I authorize Premier Surgical Associates, PLLC and Dr. _____ to perform the following medical services for me.

_____ (List Service(s) to be provided)

I understand that these service(s) have not been approved by my Primary Care Physician nor my healthcare benefit plan (Plan Name): _____ and as such will be reimbursed only to the extent they may be covered as an "Out of Network" service under my health benefits plan. I understand that, to the extent that these service(s) are not reimbursed by my healthcare benefit plan, I will be responsible for payment of all or any portion of the charges that are unpaid.

Patient's Signature _____

Date _____