Westside Surgical Associates, LLP

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Patient Name: _____ **DOB:** _____
(Please Print)

PATIENT CONSENT, ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY: I authorize the disclosure of my protected health information (PHI) from my physicians to this Practice and from this Practice to my physicians and health facilities for continuity of care.

I authorize the disclosure of my protected health information necessary to process insurance claims for the purpose of filing, payments or audits. I authorize payment directly to the Practice of all insurance claims (including Medicare).

I understand that I am personally responsible for all co-payments, deductibles, co-insurance and non-covered services as dictated by my insurance company. There is a fee of $45 if my check is returned for any reason. Outstanding accounts after 90 days are considered delinquent and at which point further action may be taken with a collection agency and attorney to settle the account; I am liable for such fees.

I have received a copy of the Practice's Privacy Policy.

_____ _____
Signature of Patient or Parent/Legal Guardian **Date**

The Practice may disclose to a family member, relative, personal friend, or any other person identified by you (the "Designated Individual") your PHI directly relevant to that person's involvement with your care or the payment for your care. The practice may also disclose your PHI to notify the Designated Individual of your location, general condition or death.

If you agree to such disclosures, please designate the person(s) below with their relationship to you:

_____

_____

_____

_____

Payment is due when services are rendered.
Terms subject to change without prior notice.