MEDICARE/INSURANCE AUTHORIZATION

I understand and agree that, regardless of deductibles and my arrangements with Medicare or any other insurance carriers, I am ultimately responsible for any balance on my account for any professional services rendered. I request that St. John's Surgery Center bill my facility and anesthesia fees and that payment of authorized benefits be made either to me or on my behalf to St. John's Surgery Center, for any services furnished to me by the facility. I authorize this holder of insurance information about me to release to the insurance company and it's agents any information needed to determine these benefits payable for related services.

Signature:_____ Date:_____

PROTECTING YOUR MEDICAL INFORMATION

St. John's Surgery Center understands that protected health information about you is personal and should be maintained in a private and confidential manner. St. John's Surgery Center is committed to protecting information related to your medical treatment. The Notice of Health Information Practices applies to all of the records generated by St. John's Surgery Center related to your treatment, payment for your treatment, and/or health care operations related to your treatment. This is to notify you that St. John's Surgery Center is in full HIPAA compliance, as required by law. Our Notice of Health Information Practices is posted in the waiting room for you to review. If, however, you would like a copy of our Privacy Practice, one will be provided upon your request.

Signature: _____ Date: _____