Ambulatory Surgery Center of Spartanburg
720 N Pine St
Spartanburg, SC 29303
(864) 504-3555

PATIENT'S FULL LEGAL NAME:

LAST: FIRST: MIDDLE:

☐ **Insurance Cards Copied** ☐ **Name & DOB Verified** ☐ **Photo I.D. Verified**

AUTHORIZATIONS / CONSENTS
PLEASE READ CAREFULLY, INITIAL EACH SECTION AND SIGN BELOW.

_______ *Please Initial* **1. Release of Information:** The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement within HIPAA guidelines, the Facility will disclose portions of the patient's medical record to person, corporation or other entity which is or may be liable for all or any portion of the Facility charges, including, but not limited to, insurance companies, health care service plans or worker's compensation carriers. The photostatic copy of this authorization shall be considered as effective and valid as the original.

_______ *Please Initial* **2. Assignment of Benefits:** The undersigned agrees, whether he or she signs as agent or as patient, to assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private and group insurance, workers compensation benefits, or other health plan to the Facility.

_______ *Please Initial* **3. Financial Agreement:** The undersigned agrees, whether he or she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he or she hereby individually obligates himself or herself to pay the account or the Facility in accordance with the regular rates and terms of the Facility. If the account is referred to an attorney or licensed collection agency for collection, the undersigned shall pay reasonable attorney's fees and the collection expenses, including agency expenses. All delinquent accounts bear interest at the legal rate.

___________________________________ ______________
Signature of Patient or Legal Guardian Date

PLACE PATIENT LABEL HERE

Revised 11/19/19