

Patient Name  
DOB



**MEDICARE AND INSURANCE CONSENT FORM**

I, \_\_\_\_\_, hereby authorize this Center to apply for benefits on my behalf for covered services rendered. I hereby authorize payment of all medical insurance benefits, which are payable to me under the terms of my insurance policy, to be paid directly to this Center for services rendered. I further authorize the release of any information needed for processing my insurance. I certify that the information I have reported with regard to my insurance is correct. I understand that I am responsible for co-insurance and services not covered by my insurance company.

I realize that I will receive a bill from my doctor's office for the surgical fee, the Center for the facility fee, if I required anesthesia, the Anesthesia Department, and the laboratory for cultures, lab testing or pathology testing for tissue examination, if applicable.

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date

**PATIENT PRIVACY**

I understand that, under the Health Insurance Portability & Accountability Act of 1996("HIPAA"), I have certain rights to privacy regarding my protected health information.

BY SIGNING BELOW I ACKNOWLEDGE BEING NOTIFIED OF THE PRIVACY PRACTICES OF BELLONA SURGERY CENTER.

Check here if you wish to receive a copy of the Bellona Surgical Center's Notice of Privacy Practices.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If patient is unable to consent on his/her own behalf, then a parent/guardian must sign below:

Signature of Parent/Guardian: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Witness \_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:
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