American Surgical Arts, PC

"Exceptional experience . . .Extraordinary results"

SEAN M. BIDIC MD, MFA, FAAP, FACS
Board Certified Plastic Surgeon
Board Certified Hand Surgeon

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INSURANCE AUTHORIZATION, ASSIGNMENT OF BENEFITS, & FINANCIAL RESPONSIBILITY

Please know that our office will do its utmost to assist you with your insurance processing, however, you, as the patient, and/or responsible party must obtain all necessary referrals, pre-authorization, etc. Any incorrect or incomplete insurance information will usually result in reduced benefits and add to the patient's financial burden. As a patient you are responsible to know your insurance coverage.

I hereby authorize the office of Sean M. Bidic, as my designated representative, to receive written and verbal claim communications and the right to appeal such claim determinations to my insurance company on my behalf, in the determination of services rendered by Sean M. Bidic, and, as part of the appeal, I hereby authorize my insurance company to disclose and furnish to my designated representative, Sean M. Bidic or staff representative, the following information:

> All medical and financial information contained in my insurance file. I understand this information is privileged and confidential.

I authorize American Surgical Arts, PC and Dr. Bidic to furnish the information concerning my illness and treatment to any insurance company. I, the patient, do hereby direct the health insurance carrier to issue payment on my behalf directly to American Surgical Arts, PC or Dr. Sean M. Bidic. I further assign to the physician all payments the insurance carriers are obligated to make on my behalf for medical/surgical services rendered by Dr. Bidic and this office. If I receive payment from the insurance carrier, I will forward my payment and the explanation of benefits directly to American Surgical Arts, PC.

I understand that my applicable insurance may not cover all fees charged by American Surgical Arts, PC. In consideration of the medical/surgical services rendered, I hereby agree to be personally responsible for payment of the charges at the time the services are performed. I understand that a finance charge of 18% per (1.5% per month) will be added to any overdue balance. I also understand that if the account is placed for collection, I am responsible for collection costs and reasonable attorney's fees.

Medicare Patients Only

I request that payment of authorized Medicare benefits be made on my behalf to American Surgical Arts, PC for any services furnished by me. I authorize any holder of medical information about me and any information needed to determine these benefits payable for related services to be released to the Health Care Financing Administration and its agents.

(See next page)

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

I authorize the use or disclosure of the above-named patient's health information.

Signature: _____ Date: _____

Name of Legal Guardian/Parent and relationship to patient, if not signed by patient:

_____