SPACE COAST
SURGERY CENTER

Financial Responsibility Acknowledgement

Payment for services is due at the time services are rendered. We accept cash, MasterCard, Visa or Check. We will submit an insurance claim on your behalf. You must notify us immediately if your insurance changes.

Your insurance company may send the payment for your procedure to you directly. If that happens, **you agree to endorse and send the insurance check to Space Coast Surgery Center**. Failure to send payment to Space Coast Surgery Center will result in further collection action.

If your account goes to Collections, you are responsible for any collection fees, legal fees or court cost.

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE CONTACT OUR BILLING OFFICE TOLL FREE AT 1-866-631-7890 SO THAT WE CAN ASSIST YOU IN THE MANAGEMENT OF YOUR ACCOUNT.

INITIAL _____

MEDICARE/MEDICAL INSURANCE BENEFITS/SOCIAL SECURITY ACT

PATIENTS' CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given to me in applying for payment under title XVIII of the Social Security Act about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

INITIAL _____

NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge receipt of the HIPPA notice. *INITIAL* _____

_____ _____

Patient Signature Date

_____ _____

Witness Signature *(Front Desk)* Date