Tuscany Surgical Center
2851 S. Ave B, Suite 2801
Yuma, Az 85364
(928)817-8900

Name (Last, First, Middle) Dob Age Sex Social Security #

_____

Address:_____

Home Phone _____ Work Phone _____ Cell Phone _____ Marital Status_____

Co-payment is due on the day of service, unless payment arrangements have been made. If the service is not covered under your policy, you are responsible for the balance due. It is the policy of Tuscany Surgical Center to work diligently to assist patients with financial arrangements.

Assignment of Benefits: I hereby authorize payment directly to Tuscany Surgical Center the benefits payable to me, but not to exceed the balance of the charges for this period of outpatient services.

Authorization: I hereby authorize release of any medical information necessary to prove this claim. I authorize Tuscany Surgical Center to correspond with the insurance commissioner for any reason. I further authorize the release of medical information to those healthcare facilities and/or physicians who may be responsible for my follow-up care.

Financial Responsibility: I understand that I am financially responsible to Tuscany Surgical Center for any amount not covered by this authorization. Within 48 hours, a claim will be filed with my insurance carrier. I will be notified when financial action (payment, rejection, etc) by my insurance carrier has been received by Tuscany Surgical Center. Payment will be expected within 10 days of that notice. In the event that this account is placed with an attorney or collection agency, I am responsible for collection fees, reasonable attorney fees and court cost.

Medicare Patients Certification, Authorization to Release Information and Payment Request: I certify that the information given by me is correct, I authorize any holder of medical or other information about me 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. I assign Tuscany Surgical Center to submit a claim to Medicare for payment for service rendered to me. I authorize Tuscany Surgical Center to release any information requested by the insurance company/companies or its representative (s).

Ownership Disclosure: I am aware that my physician may be an owner of Tuscany Surgical Center. I understand that I may choose any other outpatient facility for the purpose of having surgery performed.

I have read this policy and understand that delinquent accounts may be assigned to a credit report agency and collection services.
I authorize the release of any medical documentation to insurance companies and medical providers as necessary.

{ } I have reviewed and/or received a copy of "Patient Rights and Responsibilities".
{ } I have reviewed and/or received a copy of "Notice of Privacy Practice for Protected Health Information".
{ } I was instructed to not eat, drink or take medications (unless otherwise specified by my physician) after midnight.
{ } I understand that I will not be released by myself or with a minor. I do not plan to drive a car home.
{ } I give Tuscany Surgical Center permission to speak to my escort regarding my condition.
{ } I agree that Tuscany Surgical Center is not responsible for any valuables that I have elected to bring.
{ } All of my concerns/questions have been addressed by my physician.
{ } I have received and reviewed these documents **PRIOR** to my procedure today. The disclosure, patient rights and advanced directives.

Patient Disclosure: The following Physician owns and operates Tuscany Surgical Center located at the address above: **Dr. Ahmed Kemmou.**

Notice to Patients:
State law, A.R.S. #32-1401.213(ff) requires a physician notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient, if these services are available elsewhere on a competitive basis. Your physician supports this law because it helps patients make reasonable financial decisions concerning their health care.

ACKNOWLEDGEMENT:

I have read this "notice to Patients" and I have understood the disclosure that it contains.

Patient Signature:_____ Date:_____