Manatee Surgical Alliance
5317 4th Ave. East
Bradenton, Florida 34208
Phone: (941) 254-4957
Fax: (941) 254-4958

ASSIGNMENT OF INSURANCE BENEFITS

Medicare and Supplemental Insurance

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services ("CMS") and its agents and/or any supplemental insurance companies any information needed to determine benefits or the benefits payable for related services. I request that payment of authorized benefits be made to Manatee Surgical Alliance ("The Practice") on my behalf for any services furnished me by or in The Practice, including physician services. I authorize The Practice to act as my agent to help me assure payment from Medicare and any supplemental insurance companies. As part of my treatment, The Practice may prescribe testing procedures to be performed here. I understand, and have been advised that, according to Florida Law, I am under no obligation to use this facility. ***I understand that I am responsible for full payment of any charges, including non-covered services, deductibles, and/or co-payments due.***

______________________________ ____________________

Patient signature Date

Commercial Insurance

I authorize the release of medical information that is necessary to process claims. I understand that some, and perhaps all, of the services may be non-covered services and may not be considered medically necessary under my insurance contract. I request that payment of authorized benefits be made on my behalf to Manatee Surgical Alliance ("The Practice") for any services provided by The Practice physicians. ***I understand that I am responsible for full payment of any charges, including non-covered services, deductibles and/or co-payments due. I further understand that I am responsible to notify this office of any pre-authorization or pre-certification required by my insurance company. It is my responsibility to ensure that an authorization is on file with The Practice prior to having my procedure performed. When applicable, I understand that I am responsible for full payment of all charges in the absence of an authorization.***

______________________________ ____________________

Patient signature Date

Manatee Surgical Alliance

Stelios Rekkas, M.D.

Dear Valued Patient,

Thank you for choosing Manatee Surgical Alliance where we strive to offer the best possible medical care. It is our pleasure to welcome you as a patient. This letter is designed to provide you with some important information about our services and office operation.

Emergencies: If the office is closed and you have a medical emergency, **please dial 911 or proceed to the closest emergency room.** A question for the doctor, you can call the office number and follow instructions to reach the Answering Service. If you leave a message for the doctor to call back, please turn off any call block features that you have on your phone. If you have not received a call back from the doctor in a reasonable amount of time, please call back and he can be page again.

Prescription Policy: We do our best to be as flexible as possible with providing patients with refill prescriptions. We ask that you allow 48 hours for routine prescription refills.
My Pharmacy name/phone # is ____

Insurance/Referral Policy: If your insurance requires a pre-authorization or referral for any services, we ask that *you provide us with at least 48 hours prior notice of the appointment* in order to expedite the referral process. If we do not have adequate notice you may have to reschedule your appointment.

Cancellation Policy: Kindly give 24 hours notice if you are unable to keep your appointment. If you do not cancel 24 hours prior to your appointment, you may be subject to a $25.00 "No-Show" fee.

Same-Day Appointments: We do our best to offer same day appointments for illness and emergencies. Please understand that we are working you into our schedule and we will have limited time to address only the illness that you scheduled the appointment for.

Telephone Calls: If you need to leave a message, please note that we will do our best to return all calls by the end of the day.

Financial Policy: It is imperative that the office have your correct insurance on file at all times. Copay, Co-Insurance, Deductibles and Outstanding Balances are due at the time of service. Accounts with outstanding balances greater than 90 days old will be considered in collection status. All costs associated with sending the patient to collections will be the responsibility of the Guarantor. Payment plans can be arranged by our billing company, Partners in Practice. They can be reached at (866)419-0760.

We appreciate your selection of our office to provide your medical care and we will work hard to serve your needs.

Signature___________________________________ **Date**_____________________________

5317 4th Avenue Circle East
Bradenton, FL 34208

MSA-013 (9/12)

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Manatee Surgical Alliance, ("The Practice") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of The Practice. I understand that diagnosis or treatment of me by The Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of The Practice. The Practice is not required to agree to the restrictions that I may request. However, if The Practice agrees to a restriction that I request, the restriction is binding on The Practice.

I have the right to revoke this Consent, in writing, at any time, except to the extent that The Practice has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review The Practice's Notice of Privacy Practices prior to signing this document. The Practice's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of The Practice. The Notice of Privacy Practices for The Practice is also provided in our waiting room. This Notice of Privacy Practices also describes my rights and The Practice's duties with respect to my protected health information.

The Practice reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_______________________________________ _______________________

Signature of Patient or Personal Representative Date

_______________________________________ _______________________

Printed Name of Patient or Personal Representative Description of PR's Authority