Medical Release Protected Health Information

I, _____, (Date of Birth _____), give **Carolinas Center for Surgery** permission to speak to the following people regarding my health status; including diagnosis, treatment options, and plans/payments for health services I receive from **Carolinas Center for Surgery**.

Carolinas Center for Surgery may speak with the following:

Family and/or Friends	All Physicians you are currently seeing:
Name: _____ Relationship: _____ Phone #: _____	Name: _____ Phone#: _____
Name: _____ Relationship: _____ Phone #: _____	Name: _____ Phone#: _____
Name: _____ Relationship: _____ Phone #: _____	Name: _____ Phone#: _____

Current Pharmacy: _____

Patient Email Address: _____

Acknowledgement of Receipt of Notice of Privacy Practices for Carolinas Center for Surgery:
Patient Initials: ____

RESTRICTIONS:	May we send appointment reminders by:	
May we call you at work? Yes ☐ No ☐	Email:	Yes ☐ No ☐
Call your cell phone: Yes ☐ No ☐	Phone Call:	Yes ☐ No ☐
Leave a message on your answering machine/voicemail: Yes ☐ No ☐	Text Message:	Yes ☐ No ☐

☐ By checking this box, you give Carolinas Center for Surgery permission to access your medication history from your insurance.

Carolinas Center for Surgery files insurance as a courtesy to our patients. You are responsible for insurance co-payments and deductible amounts at the time of service. Co-pays and deductibles are also required prior to surgery.

PLEASE SEE REVERSE SIDE

Your medical insurance is an agreement between you and your insurance company to pay a specified amount for medical care. The fees of this office are not based on the amount insurance pays.

The amount approved on a particular procedure by your insurance company may be more or less than the fees charged. Full payment for your treatment remains your exclusive financial responsibility, including charges not covered by your insurance carrier.

Payment is due in full forty-five (45) days after a claim has been submitted upon your behalf. If you are unable to meet your obligation, you agree to contact the business office. This office is not prepared to wait for payments pending any legal action involving the patient and any third parties.

Those patients with no insurance are expected to make payment at the time of service unless other arrangements are made in advance.

I hereby authorize CAROLINAS CENTER FOR SURGERY to furnish information to insurance carriers concerning my illness and treatments and hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I understand all the physicians of CAROLINAS CENTER FOR SURGERY have an ownership interest in this practice, each share losses or profits of this corporation.

I, authorize CAROLINAS CENTER FOR SURGERY to appeal any claims on my behalf, should my insurance company fail to pay my claim in full. They have my permission to submit my medical records on my behalf. I understand and agree to all statements contained herein and further that my failure to comply with this agreement may subject me to collections activity, whether it is a collection agency or company attorney.

Signature of Patient: _____ **Date:** _____

Carolinas Center for Surgery Employee Initials: _____ **Date:** _____

MEDICARE PATIENTS ONLY

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers any information needs for this or a related health claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. Regulation pertaining to Medicare assignment of benefits applies. This is a lifetime authorization.

Signature of Patient: _____ **Date:** _____