TOWN CENTER
AMBULATORY SURGERY CENTER

Admission Agreement and Authorization

1. **Financial Agreement**

The charges for today's services will be billed to the listed insurance carrier(s) for payment. I allow the **Town Center ASC, LLC** to bill my insurance for the serviced rendered today. I agree to pay any financial obligation to **Town Center ASC, LLC** in accordance with regular rates and terms of the center. I understand that my account must be paid in full day from the data services, if not by the insurance carrier then by you (the patient) If the account is referred to an attorney or collections agency for collection of the balance owed to the **Town Center ASC, LLC** I (the patient) shall pay reasonable attorney's fees and the collection expense, including agency expenses. All delinquent accounts bear interest at the legal rate.

2. **For Medical Beneficiaries**

Patient's certification and authorization to release information and payment request: I certify that the information given by me (the patient) in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize release of all records required to act of this request. I request that payment of authorized benefits made on my behalf.

3. **Assignment of Benefits for Anesthesia Provider**

I hereby assign the benefits due to me (The Patient) to the provider of Anesthesia. I authorize and instruct the Insurance carrier to make payments of authorized benefits directly to the Anesthesia provider and herby authorize release to all of the records required to act on this request. I certify that the Anesthesia services covered by this claim have been received.

4. **Release Agreement**

The undersigned agrees that to the extent necessary to determine Liability for payment and to obtain reimbursement. Town Center ASC, LLC may disclose portions of the patients records, including any medical record to any person, corporation or other entity who or which is or may be liable for all or any portion of the facility charges. This includes, but not limited to: Insurance companies, health care service plans and workman's compensation carriers. A photostatic copy of this authorization shall be considered as effective as the original.

5. **Certification**

The Undersigned certifies that he/she has read the above information and is the patient, patient's legal representative, or is dually authorized by the patient to be the patient's general agent to execute this agreement and consent and accept its terms.

Patients Signature: ______________________________ Date: ____/____/____ Time: _______

Guardian/Conservator: __________________________ Date: ____/____/____ Time: _______

Witness: _______________________________________ Date: _____/_____/_____ Time: ________