MEDICARE/INSURANCE AUTHORIZATION

I understand and agree that, regardless of deductibles and my arrangements with Medicare or any other insurance carriers, I am ultimately responsible for any balance on my account for any professional services rendered. I request that St. Lucy's Eye Surgery Center bill my facility and anesthesia fees and that payment of authorized benefits be made either to me or on my behalf to St. Lucy's Eye Surgery Center, for any services furnished to me by the facility. I authorize the holder of insurance information about me to release to the insurance company and its agents any information needed to determine these benefits payable for related services.

Signature: _____ Date: _____

PROTECTING YOUR HEALTH INFORMATION

St. Lucy's Eye Surgery Center understands that Protected Health Information about you is personal and should be maintained in a private and confidential manner. St. Lucy's Eye Surgery Center is committed to protecting information related to your medical treatment. The Notice of Privacy Practices applies to all of the records generated by St. Lucy's Eye Surgery Center related to your treatment. This is to notify you that St. Lucy's Eye Surgery Center is in full HIPAA compliance, as required by law. Our Notice of Privacy Practices is posted at the front desk check-in and a copy is readily available in the magazine rack located at the front entrance of the waiting area.

Signature: _____ Date: _____