Patient Name: _____

Date: _____

MEDICARE WAIVER OF LIABILITY

Provider Name:_____ Medicare #:_____

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862(A) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. As your physician, I feel that the service listed below is in your medical interest. I believe that, in your case, Medicare is likely to deny payment for this service for the reason stated in the next sentence. I have been notified by my physician that he believes that, in my case, Medicare is likely to deny payment for the service identified below for the reason(s) stated. If Medicare denied payment, I agree to be personally and fully responsible for payment.

1. Medicare does not usually pay for this many visits or treatments
2. Medicare usually does not pay for this service
3. Medicare usually pays for only one rest home visit per mo.
4. Medicare usually does not pay for this injection
5. Medicare usually does not pay for this many injections
6. Medicare does not pay for this because it is a treatment that has yet to be proven effective
7. Medicare does not pay for this office visit unless it was needed because of an emergency
8. Medicare usually does not pay for like services by more than one doctor at the same time period
9. Medicare usually does not pay for this many services with this period of time
10. Medicare usually does not pay for more than one visit per day.
11. Medicare usually does not pay for such an extensive procedure
12. Medicare usually does not pay for like services by more than one doctor of the same or similar specialty
13. Medicare usually does not pay for this equipment
14. Medicare usually does not pay for this lab test

_____/_____/_____/_____/_____

Date Service Reason Charge Signature

AUTHORIZATION AND ASSIGNMENT

Holy Cross Anesthesiology Associate
To: Holy Cross Anesthesiology Associate

With the understanding that you will be rendering professional medical services for my treatment and I have voluntarily given consent for such treatment, I agree to the following:

Authorization and Release Information

For the purpose of reimbursement of fees for services rendered by you during my treatment, I authorize you to release any necessary information to third party payors, insurance companies, attorneys or other relevant parties to ensure payment for such services. I also acknowledge that the information provided by me regarding health care coverage is true and accurate to the best of my knowledge.

PRIVACY NOTICE

The Patient hereby consents to the disclosure of his/her individually identifiable health information by Holy Cross Anesthesiology Associate in order to carry out treatment, payment, or health care operations. The patient should review Holy Cross Anesthesiology Associate Notice of Privacy Practices For Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such notice prior to signing this consent form. Holy Cross Anesthesiology Associate reserves the right to change the terms of its notice of privacy at any time. If Holy Cross Anesthesiology Associate does change the terms of its notice of privacy the patient may request a copy from Holy Cross Anesthesiology Associate. The Patient has the right to request that Holy Cross Anesthesiology Associate further restrict how his/her health information is used or disclosed to carry out treatment, payment, or health care operation. Holy Cross Anesthesiology Associate is not required to agree to the requested restriction. However, if Holy Cross Anesthesiology Associate agrees, then such restrictions are binding to the Holy Cross Anesthesiology Associate. At all times, patient retains the right to revoke this consent in writing. The revocation shall be effective except to the extent that Holy Cross Anesthesiology Associate has already taken action in reliance on the consent. Holy Cross Anesthesiology Associate may refuse to treat patient if he/she or an authorized representative refuses to sign this form, unless Holy Cross Anesthesiology Associate is required by law to treat the patient. If the patient signs and then revokes consent, Holy Cross Anesthesiology Associate may refuse further treatment to patient unless required by law. **I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORMAND I AMTHE PATIENT OR AMAUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.**

ASSIGNMENT OF BENEFITS

To: Holy Cross Anesthesiology Associate

It is hereby acknowledged that payments I owe for services rendered by you will be assigned and directed to Holy Cross Anesthesiology Associate Anesthesia. In the event that third party payors, insurance companies or other entities forward such payment to me, I agree to assign and direct the payments to you immediately upon receipt.

Guarantee of Payment and Understanding

I understand that services rendered by you for my treatment at this surgery center will require payment, and I acknowledge complete responsibility for such payment. If determined that no insurance company or third party payor is obligated to pay for such services, or that proceeds from a liability claim will not yield payment for your rendering of professional services to me, I guarantee such payment in full no later than three months from the time of service. I further acknowledge responsibility for payment of deductibles or to the fees not covered by insurers or third payors and that were incurred by me as a result of your treatment. Should this account be forwarded to an agency for an attorney for collection of fees owed by me, I also acknowledge responsibility for payment of all reasonable collection expenses and attorney fees.

_____

Signature of patient/parent/guardian/representative Date & Time Witness