Surgical Assistant Service – Patient Disclosure Form

For your surgery your surgeon may request the services of a Surgical Assistant. There is a separate fee for these services and they will not be included in either your surgeon's fee or the hospital charges.

The surgical assistant service will file a claim on your behalf with your insurance for these surgical assistant services and although your surgeon may participate in your insurance network, the surgical assistant may not and may not be eligible for reimbursement under your insurance plan.

If your insurance denies benefits for services rendered by a surgical assistant, you will in turn be responsible for any fee charged by the assistant. This surgical assistant will bill you directly and services are due in full as per the invoice date.

Regarding the above and all other information contained in this form, I (the undersigned) acknowledge, understand, and agree as follows:

- I am the patient who will receive the surgery (or such patient's personal representative). I have read and understand this surgical assistant service policy and all information contained in this form. I have had the full opportunity to ask any questions that I may have regarding this surgical assistant financial policy. All questions have been answered to my full satisfaction.
- I authorize the payment of insurance benefits to be made on my behalf to the surgical assistant service designated for my surgery. I hereby authorize any and all release of any medical records or medical information in order to process the claim for services rendered.
- I understand that my insurance benefits may not cover these surgical assisting services and I will be personally and fully responsible for any charges incurred that are non-covered or deemed medically not necessary, or denied by my insurance carrier. I assume full responsibility for any balances that my insurance does not pay for surgical assisting services.

Patient (or Personal Representative):_____

Representative Relationship to Patient: _____

Print Patient's Name: _____ Date: _____

Physician: _____ Date of Surgery: _____

Facility: _____