ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance company to pay directly to Stonecreek Surgery Center the amount due me for Medical Benefits under this claim.
I hereby agree to pay Stonecreek Surgery Center all charges not covered by my insurance company.
I also agree that if any insurance payments are paid directly to me, I will pay Stonecreek Surgery Center within 15 days of receiving the insurance payment.

______________________________ __________________
Patient (Patient Representative Signature Date

Medicare-Medical Insurance Benefits – Social Security Act

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act about me, to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare Claim. I request that payment of authorized benefits by made on my behalf.

Date of Service	HIC/Medicare No.
Patient (Patient Representative) Signature	Date
Witness	Date

RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of any medical information necessary to process my insurance claim(s) and request that the payment of all benefits be made to Stonecreek Surgery Center for services described. I also authorize the release of any medical records to other physicians/insurance companies/acute care facilities for services needed in order to render necessary medical care pertaining to my services with Stonecreek Surgery Center.

Patient (Patient Representative Signature Date