RELEASE OF INFORMATION

I authorize Wichita Surgical Specialists, P.A. to release any information to any physician involved in my care, hospital, and/or my insurance company including the diagnosis and the records of any treatment for examination rendered to me during the period of such medical and surgical care.

ASSIGNMENT OF BENEFITS

I authorize and request payments of insurance benefits directly to Wichita Surgical Specialists, P.A. otherwise payable to me. I further certify I have provided Wichita Surgical Specialists, P.A. a complete list of the insurance companies with which I have medical and/or surgical coverage.

FINANCIAL AGREEMENT

I understand that my insurance company or payer of my health benefits may pay less than actual charges for services. I understand I am financially responsible for payments in full of all co-payments, deductibles and/or remaining balances as specified by my insurance plan. If payment is denied or not covered by my insurance, or I have no insurance, I agree to be responsible for payment in full.

I authorize and allow any text messaging regarding my appointments, scheduling, or billing as it relates to my care at Wichita Surgical Specialists.

Ambient auto scribe may be used during your office visit.

SIGNATURE _____ DATE _____
(PATIENT OR GUARDIAN IF PATIENT IS A MINOR)

PATIENT NAME (please print) _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Wichita Surgical Specialists, P.A. Notice of Privacy Practices.

PATIENT NAME (please print) _____

SIGNATURE _____ DATE _____
(PATIENT OR GUARDIAN IF PATIENT IS A MINOR)

ATTENTION MEDICARE PATIENTS ONLY

TO BE COMPLETED FOR ALL MEDICARE PATIENTS

NAME _____ DATE OF SERVICE _____

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/injury due to an automobile accident, liability accident, Workman's Compensation or other? ☐Yes ☐No
2. Is illness covered by the Black Lung Program or Veterans Administration program? ☐Yes ☐No
3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? ☐Yes ☐No

4a. If under age 65, is your Medicare coverage due to disability? ☐Yes ☐No

4b. Is patient covered by a large group health plan through patient's employer or spouse's current employer? ☐Yes ☐No

5. If 65 and over, is patient covered by Employer Group Health Plan through patient's or spouse's current employer? ☐Yes ☐No
6. Are the services to be paid by a Government Research Program? ☐Yes ☐No
7. Has the Department of Veteran Affairs authorized and agreed to pay for your care at this facility? ☐Yes ☐No

REGISTRAR NOTES:

A. If patient responds "no" to questions 1-7, Medicare is primary.
B. If patient responds "yes" to any questions, Medicare is secondary and primary insurance information must be obtained.

ONE TIME AUTHORIZATION

I request that payment of authorized Medicare Benefits be made to me or on my behalf to the Physicians of Wichita Surgical Specialists, P.A. for any services furnished to me by that group. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services.

SIGNATURE _____ DATE _____
(PATIENT OR GUARDIAN IF PATIENT IS A MINOR)