FULLERTON SURGERY CENTER

4849 W Fullerton Chicago Il, 60639

773 - 237 - 2900

ASSINGMENT OF BENEFITS

I hereby authorize payment directly to the provider of service. I understand that I am financially responsible to the provider of service.

FINANCIAL AGREEMENT

The undersigned agrees, as the patient or their guarantor, that in consideration of the service provided to the patient to obligate himself/herself to pay the provider of services account in accordance with their regular terms. Should the account be referred to attorney for collection or any collection agency, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate.

RELEASE OF INFORMATION

A. GENERAL RELEASE:

I hereby authorize *Fullerton Surgery Center* and any physician or other health care provider who may treat me to release ANY AND ALL INFORMATION IN MY MEDICAL RECORDS to:

a) Entities involved in billing and collection for *Fullerton Surgery Center* and third party payors responsible for payments of patient charges and or

b) any organization or government agency authorized to review quality, utilization and/or cost of care.

ASSERT THAT I HAVE READ AND UNDERSTAND THIS FORM, THAT I FREELY AND VOLUNTARILY ACCEPT ITS TERMS, AND THAT I AM THE PATIENT OR AM AUTHORIZED TO SIGN ON THE PATIENTS BEHALF. (If the patient's representative is signing for the patient, all references on this form "I" or "My" shall refer to the "the patient" as applicable).

Patient Name (please print	Date
Patient signature	Date
Patient's Representative	Relationship to patient