

ADVANCED SURGICAL INSTITUTE

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SERVICE AGREEMENT

The patient, or patient’s authorized agent or representative, agrees to the following terms of service:

CONSENT TO TREATMENT: The Patient voluntarily agrees to be evaluated/treated by Provider. This consent is valid and continuing until the Patient is discharged from care.

RELEASE OF INFORMATION: Provider may release all or any part of the patient’s medical record to persons or entities engaged in the activities stated below:

- A. **Insurance and Quality Review:** Persons or corporations (including insurance companies, worker’s compensation payers, hospital or medical service corporations, welfare funds, governmental agencies, or the patient’s employer), or their designees, which may be liable under contract to the Provider, any other party, the patient, a family member, or employer of the patient, for purposes of securing payment for all or part of Provider’s charges, and quality assurance, accrediting agencies, and Provider and physician liability insurance carriers to enable them to carry out their functions.
- B. **Billing and Collections:** Agents or employees of the Provider that process or duplicate medical records for billing and reimbursement purposes.
- C. **Medical Audit:** Persons or entries authorized by the Provider for purposes of conducting medical audit activities.
- D. **Other Providers:** Physicians and personnel involved in the patient’s care to provide and manage the patient’s health care. Also, information may be given to other health care providers to assure continuity of care.

I understand that I may revoke this authorization at any time, except to the extent the Provider has acted in reliance upon it or the disclosure is authorized by law. This consent to the release of patient information remains valid until expressly revoked by the patient in writing.

FINANCIAL AGREEMENT: The Patient agrees, in return for services provided, to pay his/her account balance in full or to make arrangements for payment that are satisfactory to the Provider. To the extent not expressly prohibited by applicable law, the Patient agrees to pay all charges not paid in full by his/her insurance carrier or a third-party payor. The Patient also agrees to pay reasonable attorney fees and collection expenses if the account is sent to collections.

ASSIGNMENT OF INSURANCE BENEFITS: If Patient is entitled to any policy of insurance that insures the Patient, or any party liable to the Patient, Patient hereby assigns all such benefits to be applied to the Provider. It is understood, however, that the Patient remains responsible for payment of his/her bill in full regardless of Patient’s assignment of insurance coverage. I understand that I am responsible for my health insurance deductions and co-payments.

PRICE QUOTES: The Patient understands that any price quotations given are estimates of expected services and not a guarantee.

MEDICARE PATIENTS: The undersigned certifies that all information given in applying for payment under title XVIII of the Social Security Act is correct. Patient requests that payment of authorized benefits, when received, be made to the Provider. Patient authorizes release of any information needed to act on this request.

MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ AND UNDERSTAND THESE CONDITIONS OF SERVICE, THAT I HAVE RECEIVED A COPY, AND THAT I AM THE PATIENT OR AM DULY AUTHORIZED BY THE PATIENT AS PATIENT’S AGENT TO SIGN THIS AGREEMENT AND ACCEPT ITS TERMS.

Signature: _____
Patient or Patient’s Agent or Representative

Date: _____

Relationship to Patient: _____