

# Texas United Anesthesia, PLLC

P O Box 1141 – Dickinson, TX 77539

1-877-700-7619 Toll Free

## CONSENT AND DISCLOSURE PLEASE READ BEFORE YOU SIGN

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Authorization to Release Information:** I hereby authorize the anesthesia provider or its designated representative to release information concerning examination, testing, and treatment of the above patient to any insurance company, attorney, other medical facility, or other provider requesting the said for purposes of determining eligibility for payment of health insurance claim.

**Authorization to Obtain Information:** I hereby authorize Texas United Anesthesia, PLLC to obtain information concerning examination, testing, and treatment of the patient from any insurance company, attorney, other medical facility, or provider.

**Statement of Financial Responsibility:** The undersigned agrees whether he/she signs as agent or patient, that in consideration of services to be rendered to the patient, he/she individually obligates himself to pay the account in accordance with the regular rate charged by the provider. Should the account be referred to collections, whether it is a collection agency or attorney, the undersigned agrees to pay the collections expense and reasonable attorney fees equal to 32% of the outstanding payable due. Should protracted litigation result, the court may set an attorney fee in excess of 32% of the outstanding balance.

**Consent for Treatment:** The undersigned hereby consents to examination and treatment of the patient by the provider, and to his or her designee, and to the performance of any anesthetic plan or therapeutic procedure within the scope of practice that the provider treating the patient deems necessary under the circumstances.

**Authorization to Pay Insurance Benefits and Guarantee of Payment:** I Authorize payment to Texas United Anesthesia, PLLC of any and all benefits specified and otherwise payable to me. I understand that I am financially responsible to these providers for charges not covered by the assignment. I understand that charges not payable by Insurance for any reason are my responsibility. All charges are due in full within 90 days from the date of surgery regardless of any insurance pending.

**Statement to Permit Payment of Medical Insurance Benefits to Providers:** I certify that the information given by me in applying for payment under titles V, XVII, and XIX of the Social Security Act is complete and correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its carrier any information needed for this or any related Medicare/Medicaid Claim. I request that payment of authorized benefits be made on my behalf to: TEXAS UNITED ANESTHESIA, PLLC. I hereby authorize the provider or its designated representative to obtain, from the Social Security Administration, and the agency, to release any information to establish my entitlement to Medicare/Medicaid benefits.

[ ] I acknowledge that I have received the HIPPA Notice of Privacy from Foundation Surgery Center- Dickinson per Organized Health Care Arrangement with Texas United Anesthesia, PLLC.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Agent/Guarantor:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

Texas United Anesthesia is happy to deliver safe, quality anesthesia to you or your family member. We are a health care provider independent from Foundation Surgery Center and your surgeon. In accordance with your insurance plan, you may be billed for anesthesia services after your insurance benefits have been applied. If you have any questions concerning your bill for anesthesia services, please contact our billing service, **SPECIALTY BILLING SERVICES**. They will be happy to answer your questions concerning your bill. Please do **NOT** contact your surgeon's office or Foundation Surgery Center of Dickinson as they will be unable to answer your questions concerning your anesthesia bill. Contact **SPECIALTY BILLING SERVICES** toll free at:

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