1122 Kenilworth Drive
Suite 17
Towson, MD 21204
410-337-0022
410-337-0196 fax

MEDICARE AND INSURANCE CONSENT FORM

I, ____, hereby authorize this Center to apply for benefits on my behalf for covered services rendered. I hereby authorize payment of all medical insurance benefits, which are payable to me under the terms of my insurance policy, to be paid directly to this Center for services rendered. I further authorize the release of any information needed for processing my insurance. I certify that the information I have reported with regard to my insurance is correct. I understand that I am responsible for co-insurance and services not covered by my insurance company.

I realize that I will receive a bill from my doctor's office for the surgical fee, the Center for the facility fee, if I required anesthesia, the Anesthesia Department, and the laboratory for cultures, lab testing or pathology testing for tissue examination, if applicable.

____ ________________________

(X) Patient/Parent/Guardian Signature Date

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PATIENT PRIVACY

BY SIGNING BELOW I ACKNOWLEDGE BEING NOTIFIED BY THE PRACTICES OF TOWSON SURGICAL CENTER'S NOTICE OF PRIVACY PRACTICES.

☐ Check here if you wish to receive a copy of the Towson Surgical Center's Notice of Privacy Practices.

__________________________ ________________________

(X) Signature of Patient Date

If patient is unable to consent on his/her own behalf, then a parent must sign below:

__________________________ ________________________

(X) Signature of Parent Date

__________________________ ________________________

Witness to signature Date