CATARACT CENTER FOR THE ADIRONDACKS

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ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to the Cataract Center for the Adirondacks the benefits payable to me, but not to exceed the balance of the charges for this period of hospitalization.

AUTHORIZATION: I hereby authorize release of any medical information necessary to process this claim. I authorize the Cataract Center for the Adirondacks to complain to the insurance commissioner for any reason. I further authorize the release of medical information to those healthcare facilities and/or physicians who may be responsible for the patient's follow-up care.

FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to the Cataract Center for the Adirondacks for any amount not covered by this authorization. Within 48 hours, a claim will be filed with my insurance carrier. I will be notified when final action (payment, rejection, etc.) by my insurance carrier has been received by the Surgery Center. Payment will be expected within 10 days of that notice. In the event that this account is placed with an attorney or collection agency, the undersigned is responsible for collection fees, reasonable attorney's fees and court costs.

PATIENT BILL OF RIGHTS / ADVANCE DIRECTIVE INFORMATION AND DISCLOSURE OF PHYSICIAN OWNERSHIP: I acknowledge that I have received verbally and in writing at least one day prior to my procedure the documents listed.

NOTE: YOU WILL BE BILLED SEPARATELY FOR SERVICES PROVIDED BY YOUR SURGEON AND/OR ANESTHESIOLOGIST.

CONSENT TO THE USE AND DISCLOSURE FOR HEALTH INFORMATION FOR THE TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

(The surgery center provides this form to comply with the federal government's Health Insurance Portability and Accountability Act of 1996) I understand that as part of my healthcare, Cataract Center for the Adirondacks creates and maintains health records describing my health history. I understand that the surgery center may use this information as:

I. A basis for planning my care and treatment;

II. A means of communication among many health professionals who contribute to my care;

III. A means by which third-party payors can verify that services billed were actually provided; and

IV. A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I hereby consent to the surgery center's use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of the surgery center. In addition, I acknowledge that I received on the date indicated below a copy of Cataract Center for the Adirondacks' Notice of Privacy Practices, which describes the obligations of the surgery center regarding its use and disclosure of my individually identifiable health information and my rights regarding this information. I also understand that the surgery center reserves the right to change its notice and practices. If the surgery center changes the notice, I can obtain a revised copy by asking the administrator of the surgery center. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or other healthcare operations and that the surgery center is not required to agree to the restrictions requested. If the surgery center does agree to such restrictions, however, the surgery center will comply with such restrictions.

Effective Date of Notice April 14, 2003

I request the following restrictions to the use of disclosure of my health information:

____ ________________ ________________
Signature of patient or patient's representative MR# Date

Printed name of patient's representative:____

Relationship to patient:____