The Surgeons' Group, P.C.
917 Tuscaloosa Avenue, S.W. Birmingham, AL 35211
205-780-7150 phone | 205-783-9326 fax

OUR POLICIES

The Surgeons' Group P.C. prides itself on one-on-one, personalized patient care. To keep our commitment to excellent service, we ask that you review our policies.

Please sign and date at the end of this form to confirm that you understand and will follow The Surgeons' Group Policies.

Consent for Treatment/Release of Information: I consent to necessary medical treatment as determined by my physician that may be used by the physician/staff of The Surgeons' Group P.C. I authorize TSG to use and disclose protected health information (HPI) about me to carry out treatment, payment and operations. (TSG Notice of Privacy provides details on such use and disclosure).

Assignment of Benefits and Guarantee of Account: I authorize payment directly to TSG of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits. I understand that I am financially responsible to TSG for charges not covered by this assignment. For services furnished by TSG I hereby guarantee the payment of all accounts for services rendered.

The Surgeons Group P.C. will make every effort to assist our patients in understanding the scope of your insurance benefits and the method of determining your coverage. Nevertheless, it is ultimately your responsibility to understand your policy, its benefits, and the obligations it places on you. It is not the responsibility of The Surgeons' Group P.C. to verify your insurance coverage (this includes information as far as our physicians in or out-of-network status) or determine which services are or are not covered Additionally, it is your responsibility to ensure that laboratory tests, X- rays, and consultations are covered by your insurance. Therefore, if your insurance denies payment for any reason, the amount owed is your responsibility and must be paid promptly.

I have read and understood the above information and accept full responsibility if my insurance does not pay for services rendered.

Signee Printed Name: _____ **Patient's Name:** _____

IF SIGNING AS A RESPONSIBLE PARTY

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE **DATE SIGNED**