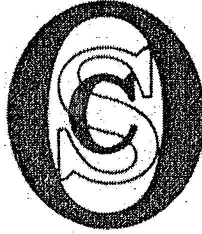

OMAHA SURGICAL CENTER

ASSIGNMENT OF BENEFITS/PRIVACY CONSENT

I hereby assign payment directly to the Omaha Surgical Center, all surgical and/or medical benefits otherwise payable to me for its services.

I understand that unpaid deductibles and/or estimated co-pays are due and payable the day of surgery. Charges not payable by insurance are my responsibility and are due in full within 60 days from the date of surgery regardless of any insurance pending.

I also authorize the Omaha Surgical Center to release information required in the course of treatment, to my insurance company, peer review or hospital (if transferred for follow-up care).

I give Omaha Surgical Center my consent to use or disclose my protected health information's to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I understand that I have the right to request restriction of how my processed health information is used. However, I also understand that the Omaha Surgical Center is not required to agree to the request. If Omaha Surgical Center agrees to my requested restriction, Omaha Surgical Center must follow the restriction(s). I have the right to be notified in the event of a breach of my private healthcare information. I have the right to request that a health plan not be informed of treatment that was paid for in full. That consent is required prior to use or disclosure of my psychotherapy notes or the use of my private healthcare information for marketing purposes. I have the right to opt out of communications for fundraising purposes. Omaha Surgical Center prohibits from disclosing genetic information for underwriting purposes.

I have been informed that I may review the Omaha Surgical Center's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent. I understand that Omaha Surgical Center has the right to change their privacy practices and that I may obtain any revised notices at the Omaha Surgical Center. I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I acknowledge that I have read and understand the Patient Bill of Rights that has been provided to me.

Signature____ Date____________________

If signed by patient representative, state relationship to patient______________________________