UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE
UNIVERSITY SPECIALTY CLINICS®

Authorization Regarding Payment and Release of Medical Information

Patient's Name: _____ Chart #: _____

I hereby authorize and request the payment of services from Medicare, Medicaid and/or other insurance plans or payors be made on my behalf to University Specialty Clinics – Surgery. I hereby assign to University Specialty Clinics – Surgery all payments for treatment services. I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid and/or other insurance plans or payors.
(PLEASE READ THE ATTACHED FINANCIAL AND INSURANCE POLICY FOR OUR PRACTICE)

I hereby authorize the release of medical information to Medicare, Medicaid and/or insurance plans or other payors. I also authorize the release of medical information to other healthcare providers including, but not limited to, my primary care or family physician, consulting physicians or healthcare providers, hospitals, rehabilitation center, or other healthcare providers or facilities. I authorize my healthcare providers to review my prescription history from my pharmacist(s) for purposes of treatment. I permit a copy of this authorization to be used.

_____ _____
Patient's/Patient's Representative's Signature Witness Signature

_____ _____
Date Date

_____
Printed Patient's or Representative's Name

_____
Representative's relationship to Patient

Consent to Treatment

I hereby agree to and give consent to the physicians, healthcare providers, associates, consultants and residents of University Specialty Clinics – Surgery to diagnose and treat me. I consent to any and all treatment including, but not limited to, physical examinations, psychological examinations, x-rays, laboratory procedures, and other procedures related to routine diagnosis and treatment as determined appropriate by the practice's physicians, healthcare providers, associates, consultants and residents.

_____ _____
Patient's/Patient's Representative's Signature Witness Signature

_____ _____
Date Date

_____
Printed Patient's or Representative's Name

_____
Representative's relationship to Patient

DEPARTMENT OF SURGERY
Two Richland Medical Park, Suite 306, Columbia, SC 29203
803-545-5800, FAX 803-933-9545

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FINANCIAL POLICY

Credit is extended to those patients who need it. However, our policy is
CREDIT ARRANGEMENTS MUST BE MADE BEFORE SERVICES RENDERED

By making arrangements in advance for timely payment and keeping your account current, you can avoid the risk of future credit problems with this office.

INSURANCE

Payment of medical fees is the responsibility of the patient. Your insurance company accepts your premium and is responsible to you for reimbursement. We will furnish you with enough information and assistance to file claims BUT we cannot be responsible for collecting your insurance payments. We will allow 45 days for your insurance company to pay assigned claims at which time we will hold you the patient responsible for payment of the account. All co-payments must be made at the time services are rendered. No exceptions

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