FIFTH AVENUE SURGERY CENTER

AUTHORIZATION AND CONSENT

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION TO INSURANCE COMPANY

I hereby assign payment to FIFTH AVENUE SURGERY CENTER (FASC) insurance benefits otherwise payable to me but not to exceed the balance FASC regularly charges for the episode of treatment. I understand that I am financially responsible to the FASC for charges not covered by the authorization. Authorization is hereby granted to release to the above mentioned INSURANCE COMPANY(S) information as the company may request complete Centers insurance claim where applicable.

CERTIFICATION FOR MEDICARE PATIENTS (ONLY)

Patient's Certification. Authorization to release Information and payment Request

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act to be correct. I authorize any holder of medical and other information about me to release to the Social Security Administration or its intermediaries claim. I request payment of authorized benefits to be made in my behalf, where applicable.

I hereby release FASC from any responsibility for valuable, money or personal possessions which may be brought to the Center by me and which may be taken from me to properly carry out any procedure for my care, or for any article left in the Center which are not claimed by me or in behalf within (30) days after my discharge.

______________________________	______________________________
Patient's Signature	**Signature of Person Authorized to consent For Patient**
______________________________	______________________________
Date	**Relationship to Patient**