AUTHORIZATION FOR ANESTHESIA SERVICES

Facility: _____

Patient Name: _____ Medical Record#: _____

Date of Service: _____ Account#: _____

IMPORTANT INFORMATION
PLEASE READ CAREFULLY

1. Anesthesiologists Are Not Employees or Agents of this health care facility- I understand that the anesthesiologist(s) and anesthesia staff are independent contractors and are not employees or agents of this health care facility. I understand that they are independent in the exercise of decisions requiring professional medical judgment, including decisions about my care. I understand that I may receive separate bills for such anesthesia services.

2. Assignment and Coordination of Insurance Benefits – I agree to provide information regarding all group hospitalization, health maintenance organization, workers' compensation, automobile and other health care benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from my insurance carrier(s)/health benefits plan(s) to the Anesthesia Group for services rendered to me.

3. Unauthorized, Non-Covered, or Out of Plan Services — I understand that if my insurance company or health maintenance organization does not consider this or any service rendered during this procedure a covered service or has not authorized this service, they will not pay for the services, or a particular charge for a service rendered during this outpatient visit. I agree to be fully responsible for payment to the Anesthesia Group providing services to me/the patient for this procedure or any related service if determined by my insurance company or health maintenance organization to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, deductible, co-insurance of the charge. I also understand that the Anesthesia Group may not participate with all health plans and networks, and may not be in-network physician members of my managed care health plan. In the event that my managed health care plan does not reimburse these services provided to me I acknowledge that I will be responsible for any balance that it declines to pay for such services

4. Authorization to Release Information and Process Claims – I authorize release of information, including financial information and confidential health information and medical records regarding services rendered during this care or any related services to my insurance carrier(s). A photocopy of this authorization may be honored. Capital Anesthesia Services has entered into an agreement with this healthcare facility which provides a HIPAA Notice to patients. This facility's HIPAA notice to patients applies to Capitol Anesthesia Associates.

5. Responsibility for Payment – In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, co-insurance and non-covered services. I request and authorize that payment of authorized Medicare benefits be made on my behalf to the Anesthesia Group for services rendered to me. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

By signing below, I certify that I have read and understand the foregoing, have had the opportunity to ask questions, and have them answered, and accept the above conditions and terms. I further certify that I am the patient listed above or am the guardian, duly authorized representative, parent or other family member of the patient.

_____ _____
PATIENT (GUARDIAN, ETC.) DATE

_____
RELATIONSHIP TO PATIENT (IF NOT SIGNED BY PATIENT)

_____ _____
WITNESS DATE

Anesthesia Services are provided by the Anesthesiologists and Certified Nurse Anesthetists of Capital Anesthesia Associates. If you have any questions about your bill, please contact Capital Anesthesia Asso., Patient Accounts Department at (703) 471-0919. Fax, (703) 742-9081 Mailto: CapitalAnesthesia Associates. P.O. Box 2728 Reston, VA 20195.

CAA ASC December 2015