Los Gatos Surgical Center
15195 National Avenue, Suite 100
Los Gatos, CA 95032

Authorization To Pay Benefits To Providers

I hereby authorize payment for services (benefits otherwise payable to me), to be made directly to providers of such services.

Authorization To Release Information

For the purpose of determining eligibility for benefits and claims processing, I hereby authorize Los Gatos Surgical Center to receive from and/or provide to medical practitioners, medically related facilities, insurance companies, or employer, information as to any physical or mental condition of myself or my covered dependents. I know that I have the right to receive a copy of this Authorization. I agree a photographic copy is valid as the original and that it shall be valid for two (2) years and six (6) months from the date shown below. I hereby certify the information provided is correct and true to the best of my knowledge.

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Signature (Patient / Parent / Guardian)

Financial Agreement

I understand that I am responsible for payment of my account regardless of my insurance coverage. Insurance company billing is provided by Los Gatos Surgical Center as a courtesy. On disputed claims or coverage the Los Gatos Surgical Center will not accept responsibility for collecting insurance payments. All bills are due and payable in full within 30 days from the date of billing.

____________________________________ ________________
Signature Date