LONG ISLAND SURGERY, P.C.

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PATIENT NAME: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of Long Island Surgery's Notice of Privacy Practices, detailing how this practice may use my protected health information. I understand that if I have any questions or concerns about the Notice of Privacy Practices, I may contact the Privacy and Security Officer. I also understand that this notice may change at any time, and that a current copy is posted in all practice locations and online, and copies are available upon request.

_____ _____ _____
Signature of Patient/Authorized Representative | Printed Name/Relationship if Representative | Date

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SIMPLE AGREEMENT

I authorize the doctor to deposit checks received on the patient's account when made out to the patient.

_____ _____ _____
Signature of Patient/Authorized Representative | Printed Name/Relationship if Representative | Date

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ASSIGNMENT OF BENEFITS

I herby instruct and direct my insurance company to pay by check made out and mailed to:

Long Island Surgery
4 Phyllis Drive, Suite B
Patchogue, NY 11772

or, if my current policy prohibits direct payment to the practitioner, I herby direct you to make out the check to me and mail it:

In Care Of Long Island Surgery
4 Phyllis Drive, Suite B
Patchogue, NY 11772

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjustor and/or attorney involved in this case. I authorize the practice/doctor to initiate a compliant on my behalf to the Insurance Commissioner for any reason.

_____ _____ _____
Signature of Patient/Authorized Representative | Printed Name/Relationship if Representative | Date

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CONSENT FOR TREATMENT

I herby consent to evaluation, testing and treatment as directed by my Long Island Surgery physician(s) and his/her designees.

_____ _____ _____
Signature of Patient/Authorized Representative | Printed Name/Relationship if Representative | Date