UPLAND SURGICAL ASSOCIATES

GENERAL CONSENT

I hereby consent to medical treatment deemed advisable by the Professional staff.

____________________ ____________________________

Date — Patient or Legal Guardian's Signature

May we please have your signature for assignment of benefits, so that we may bill your insurance plan.

Thank you,
Upland Surgical Associates

I hereby authorize direct payment of Medical/Surgical benefits to Upland Surgical Associates.

____________________ ____________________________

Date — Signature

MEDICARE BENEFICIARY

Name: ____________________________________

Print name

I request that payment of authorized Medicare benefits be made either to me or on my behalf to (name of physician or supplier) for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

________________________________ _______________

Signature — Date