Premier Surgical Assisting, LLC
KAD Surgical Assisting, Inc.
10297 SW West Park Avenue, Port St. Lucie, FL 34987
Office: 561-251-1309 Fax: 772-345-6120

PATIENT CONSENT FOR SURGICAL ASSISTANTS

Patient Name:_____

Address:_____

Date of Surgery:_____ Procedure:_____

We are proud to deliver state-of-the-art surgical care with emphasis on patient safety and quality outcomes. We provide the services of a Certified Surgical First Assistant (CSFA) that is not an employee of the surgeon or the hospital.

The surgeon's assistant is a Certified Surgical First Assistant who is formally trained and highly skilled, credentialed surgical health professional who works under the direction of the surgeon performing surgical procedures. The CSFA serves as a member of the surgical team who may perform tasks under the direction of surgeon to aid them in conducting surgery.

- The assistant at surgery will be Kathleen A. Duffy, CSFA, CSA, who is a nationally certified surgical first assistant. As a courtesy to you, the fee for the assistant at surgery will be billed directly to your insurance company. **These services may or may not be covered by your health insurance company**.
- *If it is not covered through your insurance, you will be responsible for a $350.00* fee. You will be billed directly for this service.
- If the payment of this service is applied to your deductible, you will receive a bill directly for the amount applied to the deductible.
- Insurance companies that do pay the surgical assistant fees may send the payment directly to you, the patient. On the explanation of benefits, which should come attached to the check, it will indicate what provider rendered the services. It is your responsibility to remit payment directly to the provider.
- If timely payment is not made in full, the account will be forwarded for collections and you agree to reimburse the above-named surgical assistant for all collections and/or legal fees and costs incurred. .

Please do not hesitate to contact the billing office with questions at patientquestions@mederiservices.com or via telephone at 877-563-3374

I,_____, have read and understand the above explanation regarding the role and services to be provided by Surgical First Assistant in the operating room. I understand that I will be responsible for all charges not covered by my insurance plan.

_____ _____

Patient Signature Date

Surgical Assistant Patient Disclosure

Regarding your upcoming surgery, your doctor has determined that in order to safely and properly perform your operation, the aid of a credentialed and trained surgical assistant is required. Therefore, you may see a bill submitted for surgical assistant services to your insurance company.

A surgical assistant is formally trained and highly skilled health care professional who works under the direction of the surgeon performing surgical procedures. Although they work as a member of the surgical team, they are not employed by the surgeon or the hospital.

As a courtesy to you, the fee for the assistant at surgery will be submitted directly to your insurance company. In many cases your insurance company will cover these charges. However, you will be responsible for any co-pays, deductibles, or policy exclusions. You *may* be billed for this balance after receiving an explanation of benefits from your insurance company. Insurance benefits statements can be confusing. The only charges you may be responsible for would be itemized in the final invoice to you from the billing company.

If, for whatever reason, the payment for the surgical assistant is not covered by your insurance company, you will be responsible for a fee for your surgical procedure not to exceed $350.00. Unfortunately, most Medicare policies do NOT reimburse independent surgical assistants therefore, you will be responsible for the above mentioned fee.

If the payment for the service is applied to your deductible, you will receive a bill directly for the amount applied.

Insurance companies that do pay the surgical assistant fee sometimes send the payment directly to the patient. If you receive a check from the insurance company, on the explanation of benefits that will come attached to the check, it will indicate which provider rendered the services. It is your responsibility to remit payment directly to your provider. Failure to do so in this case will result in your account being forwarded to collections for the full amount of the check in addition to any collection fee up to 35% of the amount due and any legal costs incurred.

If you do receive a bill, please do not hesitate to contact the billing office with any questions. The contact information will be provided on any statement you receive. We will be happy to assist you in any way possible.

Patient Name: _____

Patient Signature: _____

UnitedHealthcare®

Designation of Authorized Representative

Member Name (*please print*)	Date of Birth	Member ID number	
Member's Street Address	City	State	Phone
Name of Individual/Company/Law Firm being designated as the authorized representative			
Kathleen A Duffy/Premier Surgical Assisting, LLC			
Designated Representative's Address	City	State	Phone
10297 SW West Park AVE	Port Saint Luc	FL	561-251-1309
Provider of Service			
Kathleen A Duffy			
Date(s) of Service or Proposed Service			

I, _____, do hereby appoint
Print the name of the member who is receiving the service or supply

Kathleen A Duffy/Premier Surgical Assisting, LLC
Print the name of the person who is being authorized to act on the member's behalf

to act as my authorized representative in requesting (*check all that apply*)
☑ a complaint ☑ an appeal ☑ documents

from UnitedHealthcare regarding the above-noted service or proposed service.

I understand and agree that:

- This authorization is voluntary;
- my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information:
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulation;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of Member:	Date:
If person signing this authorization is not the member, describe relationship (i.e., parent, legal representative)	

Legal Representatives signing this authorization on behalf of a member must furnish a copy of a health care power of attorney, or other relevant document that grants the applicable legal authority.

Designation of Authorized Representative

Member Name (*please print*)	DOB	Member ID number	
Member's Street Address	City	State	Phone
Name of Individual/Company/Law Firm being designated as the authorized representative			
Kathy Duffy/KAD Surgical Assisting Inc			
Designated Representative's Address	City	State	Phone
10297 SW West Park AVE	Port Saint Lucie	FL	561-251-1309

Provider Name:	Date(s) of service or proposed service
Kathy Duffy	

I, _____ do hereby name

Print the name of the member who is receiving the service or supply

Kathy Duffy/KAD Surgical Assisting Inc

Print the name of the person who is being authorized to act on the member's behalf to act as my authorized representative in requesting *(check all that apply)*

☑ a complaint ☑ an appeal ☑ documents

from my insurance company regarding the above-noted service or proposed service.

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Signature of Member	Date
If person signing this authorization is not the member, describe relationship to the Member (i.e. Parent, Legal Representative)	

Legal Representatives signing this authorization on behalf of a member must furnish a copy of a health care power of attorney, or other relevant document that grants the applicable legal authority

Designation of Authorized Representative

Member Name (*please print*)	DOB	Member ID number	
Member's Street Address	City	State	Phone
Name of Individual/Company/Law Firm being designated as the authorized representative			
Kathleen A Duffy/Premier Surgical Assisting, LLC			
Designated Representative's Address	City	State	Phone
10297 SW West Park AVE	Port Saint Lucie	FL	561-251-1309
Provider Name:	Date(s) of service or proposed service		
Kathleen A Duffy			

I, _____ do hereby name

Print the name of the member who is receiving the service or supply

Kathleen A Duffy/Premier Surgical Assisting, LLC

Print the name of the person who is being authorized to act on the member's behalf to act as my authorized representative in requesting *(check all that apply)*

☑ a complaint ☑ an appeal ☑ documents

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