



PRIVACY PRACTICES, PATIENT BILL OF RIGHTS AND RESPONSIBILITIES, EPRESCRIBING, & FINANCIAL POLICY

Thank you for choosing St. Louis Surgical Consultants as your healthcare provider. We are committed to providing excellent healthcare services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our policies.

- Please be sure to provide us with your most current insurance information.
- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- Please be aware that some or perhaps all of the services may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.
- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that if you are a participant in an HMO plan you must obtain an insurance referral from your Primary Care Physician listed on your Insurance Card before you are seen by another healthcare provider.
- Co-Payments are due at time of service.
- You must provide your most current billing address, all available telephone numbers and any other important contact information and if any of this changes, it is your responsibility to contact us with the updated information.
- You have the right to request a copy of the St. Louis Surgical Consultants Notice of Privacy Policy.
- By signing below, you acknowledge that you have reviewed the "Notice of Privacy Practices" for St. Louis Surgical Consultants and understand that you may contact the person named in the Notice if you have questions about the content of the notice.
- By signing below, you acknowledging that you are either the patient or the patient's personal representative and authorize the release of all applicable medical information, including & without limitation, copies of all records and test results produced to the designated attending, referral, and/or follow-up physicians and such other health care practitioners or organizations who/which will be providing subsequent monitoring of care or treatment in connection with care provided by St. Louis Surgical Consultants.
- By signing this consent form you are agreeing that SLSC can request and use your prescription medication history from other healthcare Providers and/or third party pharmacy benefit payers for treatment purposes and provide informed consent to be enrolled in the ePrescribe program.

By signing below you acknowledge that you have read the information above and fully understand its terms.

Date: _____ / _____ / _____

PRINTED Patient Name _____
Please Print

Patient/Responsible Party SIGNATURE _____