

## Insurance Billing Notice

### Responsibilities of Ozark Surgical Group:

- Ensure that our physicians are in network with your insurance carrier.
- Obtain prior authorization or pre-certification and verify insurance benefits prior to scheduling.

### Patients should know and agree to:

- Obtaining prior authorization or pre-certification is not a guarantee of payment.
- Co-insurance and deductibles (if applicable) are your responsibility.
- Insurance denials due to a pre-existing condition are your responsibility.

I understand the above statements as they pertain to my insurance and fees. Any balance on my account after insurance has paid is my responsibility.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness / Office Staff

\_\_\_\_\_  
Date

## Authorization to Release Medical Records/information

I authorize \_\_\_\_\_ to provide in writing to

**Ozark Surgical Group, 901Burnett Drive, Mountain Home, AR 72653 Fax 870-424-4470**

a report of my diagnosis, treatment, prognosis and recommendations as well as other data pertinent to my

treatment during the period from: ☐ all dates ☐ \_\_\_\_\_ to  
\_\_\_\_\_.

Specific records requested \_\_\_\_\_

A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name:

\_\_\_\_\_  
Print

\_\_\_\_\_  
Date of Birth



\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
SSN

\_\_\_\_\_  
Date