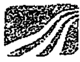

Crystal Run℠
Ambulatory Surgery Center

95 Crystal Run Road
Middletown, NY 10941
845•703•3800

Acknowledgment/ Authorization

Date ____

Patient Name ____________________________________

Date of Birth_____________________________________

I hereby acknowledge I have received Crystal Run Ambulatory Surgery Center of Middletown Notice of Privacy Practices.

I consent to examination and treatment by the physicians and nursing staff of Crystal Run Ambulatory Surgery Center of Middletown.

I request that payment of authorized Medical, Workers Compensation, No-Fault or Government insurance benefits be made on my behalf to Crystal Run Ambulatory Surgery Center of Middletown for services furnished to me by the provider.

I authorize the release of any medical or other information necessary to process claims.

I understand and agree that any dollar amounts quoted to me prior to the date of surgery are estimated amounts only and may change as my insurance processes the claims.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.

Patient Signature____

Date ____