The C.S.I.
The Center For Surgical Intervention

PATIENT ENDORSEMENT/RECORDS RELEASE/ FINANCIAL AGREEMENT

I hereby authorize treatment of the person named below by The Center for Surgical Intervention: _____
(Print Full Name)

I authorize The Center for Surgical Intervention to release any information concerning my healthcare treatment including diagnosis, examinations and treatments to insurance companies, other healthcare facilities and any legal council that may be associated with your treatment.

I request and authorize payment from my insurance company be made on my behalf for any services furnished to me by the provider, The Center for Surgical Intervention.

Should there not be any insurance benefits available, I fully understand and accept full responsibility for **any** and **all** bills incurred.

In the event that your insurance company pays your insurance claims but makes the checks payable to you (the patient), I authorize The Center for Surgical Intervention to deposit those checks in their accounts in order to credit my account for payment.

This authorization is in effect until I give written notification stating otherwise.

I, _____ have read and agree to all of the terms above. (Print Name)

_____ D.O.B_____
Patient Signature

_____
Date

_____
Witness

Office - 5950 S. Durango Dr. Las Vegas, NV 89113 • Phone 702-562-3039 • Fax 702-562-6928
Billing/Correspondence • 9811 W. Charleston Blvd. Suite #2-389 • Las Vegas NV 89117