Summa Health™ | Medina Surgery Center

REQUEST TO RESTRICT DISCLOSURE OF INFORMATION TO INSURANCE HEALTH PLAN FOR ITEMS OR SERVICES PAID IN FULL

I, _____ request Medina Surgery Center to withhold information related to the following health care item(s) or service(s) from my insurance company/health plan _____(name) for payment purposes. The items(s)/service(s) I am electing not to have disclosed to my health plan are:

_____
_____
_____
_____
_____
_____.

I understand that I will be responsible for making payment in full for these services within **30 days** of receiving the billing statement. I further understand that by electing to pay for these services, I am not eligible for any Financial Assistance Program.

I understand that I am responsible for informing additional providers or providers of follow up services of my request for restriction. I understand that this information may be disclosed if required by law.

If payment is not made in full within **30 days** of receiving the billing statement, I understand this request/agreement will be revoked and Medina Surgery Center will be permitted to disclose all information related to these services to the health plan for payment purposes.

_____ _____
Patient Signature Date

_____ _____
Patient Access Representative Signature Date

Affix Patient Label Here