AFFIRMATION BY LETTER OF PROTECTION PATIENTS

I, the Patient, am providing Miami Surgical Center (MSC) with all of my insurance information below. This includes all of my automobile insurance and/or health insurance policies and/or any other insurance policies under which I am covered.

I understand that if I fail to provide any and/or all such insurance information at this time, MSC will not be responsible for seeking payment now or in the future from any undisclosed insurance carrier or any other third party; instead, MSC will have the right to seek payment directly from me and/or my attorney.

I have read and fully understand the above, and affirm that the information provided below is complete, true and correct.

Automobile Insurance:		**Bill**	**Do Not Bill**
_____	Name of Insurance Company		
_____	Insurance Policy Number	_____	_____
_____	Telephone Number	(Initial)	(Initial)

Health Insurance:			
_____	Name of Insurance Company		
_____	Address of Insurance Company	_____	_____
_____	Insurance Policy Number	(Initial)	(Initial)
_____	Telephone Number		

Other Insurance:			
_____	Name of Insurance Company		
_____	Address of Insurance Company	_____	_____
_____	Insurance Policy Number	(Initial)	(Initial)
_____	Telephone Number		

1. _____ Please initial here and use the back of this form if additional space is needed to list additional insurance companies.

2. _____ Please initial here if you have no insurance benefits available to you.

Patient's Printed Name: _____Patient's Signature:_____

Witness: _____ Date: _____