Northwell Health | Suffolk Surgery Center

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF RIGHT TO REQUEST INFORMATION FROM THE SUFFOLK SURGERY CENTER ABOUT THE AMOUNT OR ESTIMATED AMOUNT THAT THE SUFFOLK SURGERY CENTER WILL BILL YOU DIRECTLY FOR MEDICAL SERVICES

This Notice provides information to you about your right to request from the Suffolk Surgery Center information about the amount or estimated amount the Suffolk Surgery Center will bill you directly for medical services if the Suffolk Surgery Center is not a participating provider in your health insurance plan.

By signing this form, you acknowledge that you have received this Notice of Your Right to Request Information from the Suffolk Surgery Center about the amount or estimated amount which the Suffolk Surgery Center will bill you directly for medical services.

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Patient Name or Representative (Print)

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Patient Name or Representative (Signature)

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Date