American Surgery Center

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CONDITIONS OF OUTPATIENT ADMISSION

Please read each section carefully and then sign and date. Please let us know if you have any questions.

1. I, the below named patient or authorized representative hereby authorize the surgeon hereby referred to as the surgeon indicated on the informed consent form for procedure and/or his/her associates or assistants of his/her choice to perform operation indicated on the operative consent or any other therapeutic procedure upon the patient indicated herein they may deem necessary or advisable. The necessity for the operation and the potential risks of the operation has been explained to me by physician and no warranty or guarantee has been made as to the result or cure.
2. I hereby authorize the surgeon and/or his/her assistants to provide such additional services to patient as he/she or they may deem necessary or advisable including procedures different from those now contemplated, and including but not limited to the administration and maintenance of anesthesia, nursing services, radiological and pathological services, and photography, videotaping and recordings of the operation and any other part of the patient's visit at the facility hereby referred to as American Surgery Center LLC. for medical or educational, quality assurance and security purposes.
3. I hereby authorize the surgeon to use his/her discretion in the retention, preservation or disposal of my severed tissue or member.
4. I hereby authorize all doctors, pharmacists, hospitals, the American Surgery Center, or other institutions or individual rendering care and treatment to furnish the responsible parties and/or insurance companies with full information regarding treatment rendered (including copies of my records). A photographic copy of this authorization shall be considered as effective and valid as the original.
5. I hereby acknowledge that I have reviewed and fully understand the Patient Bill of Rights/Responsibilities as well as the HIPAA Notice of Privacy Practices. I understand that I can speak with the compliance officer if I have any questions.
6. I understand that the surgical and/or diagnostic procedure to be performed on me at the facility will be done on an outpatient basis and that the facility does not provide 24-hour patient care. If my attending practitioner, or any other qualified physician in his/her absence, shall find it necessary or advisable to transfer me from the facility to a hospital or other health care facility, I consent and authorize the employees and the facility to arrange for and effect the transfer. I also authorize the hospital/treatment facility to which I am transferred to release treatment information, including the discharge summary, to the surgery center.
7. I authorize the American Surgery Center to release information, including any record, bills for services rendered, opinions, reports, x-rays in my medical chart, with respect to the treatment of the above-referenced patient, including any confidential HIV-related information, to any third-party who may be responsible for the payment or inquiry of my account, any alternative caregiver, and any accrediting review agencies as may be necessary.
8. I understand, I am financially responsible to pay the facility any charges incurred by the patient and promise to pay the facility promptly the amount of such charges which are not paid by any insurance carrier for any reason. I agree that in the event my account should become delinquent, I will pay all

reasonable attorney fees, court costs, and other expenses pertaining to the collection of such account whether or not a lawsuit is commenced in connection with such collection efforts. I understand that any medical insurance payment sent to me directly for services rendered at the facility indicated herein must be turned over to American Surgery Center.

9. I acknowledge that I was given written instructions including information necessary to facilitate my preoperative, intraoperative and postoperative care. I understand and agree to abide by the instructions contained in the sheet.
10. I understand that any Advance Directive I may have will be not be honored at the American Surgery Center as this is an outpatient Surgery Center and all measures necessary for resuscitation will be executed at this center.
11. I hereby acknowledge receipt of a list of physicians who have financial interest or ownership in the facility. I understand that I have the option to use a health care facility of my choice.
12. I hereby acknowledge that American Surgery Center has surveillance cameras in common areas. Surveillance cameras will not be used in private areas such as restrooms and operating rooms. The cameras run 24 hours a day and 7 days a week. Only management personnel are authorized to view recordings. There may arise situations wherein recorded material is necessarily used in the investigation and reporting of theft, assault or other reportable incidents. During these investigations my privacy may be compromised. If the recorded material is ever used in the investigation and reporting of reportable incidents, documentation will be made of the persons who viewed the recorded segments and their credential.
13. I understand that it is my responsibility to advise facility of any changes in the patient's name, address, phone number, and/or insurance information
14. I understand that I am responsible for understanding the provisions of my insurance policy. I agree to inform the facility of any other health insurance plan I may have.
15. I understand that the facility will not be responsible for any disputes between me and my insurance company other than to supply factual information.
16. I understand that this facility cannot guarantee payment of claims.
17. I understand that the facility reserves the right to take lawful actions including referring my account to a collections agency and report to one or more credit bureaus for non-payment.

_____ _____

Patient's/Authorized Signature Date Witness Signature Date

_____

Patient's/Authorized Name

If financially responsible/insured person is other than Patient/Legal guardian, please sign below:

_____ _____

Authorized Signature Date Witness Signature Date

_____

Authorized Name