ADVANCED SURGICAL CENTER
SURGERY CENTER ADMISSION AND FINANCIAL AGREEMENT

LEGAL RELATIONSHIP BETWEEN SURGERY CENTER AND PHYSICIANS: I understand that all physicians furnishing services to the patient, including the patient's physician, and any specialist such as an anesthesia provider, radiologist or pathologist are independent contractors with the patient and are not employees or agents of the surgery center. The patient is under the care and supervision of his/her physician, and it is the responsibility of the surgery center and its staff to carry out instructions of the physician. It is the responsibility of the patient's physician to obtain the patient's informed consent, to medical or surgical treatment or procedures. Any questions concerning the nature or results of any examination or treatment should be directed to the patient's physician and not to the surgery center employees.
OTHER PROFESSIONAL RELATIONSHIPS: I understand that my physician may have a professional radiology service review radiological image. My physician may also send specimens to a professional pathology laboratory for a pathological diagnosis. Radiology and pathology services are billed separately by those individual physicians and laboratories. I understand that approved company representatives and vendors may be present during my procedure, however they will not participate in my procedure. I understand that students may be in attendance during my procedure. Students are under direct supervision of the physician and will not participate in my procedure without direct supervision of my physician.
PERSONAL VALUABLES: It is agreed and understood that the surgery center shall not be responsible for any personal property brought by patient to the surgery center, including but not limited to money, jewelry, documents or any other articles.
OWNERSHIP OF SURGERY CENTER: I understand that my physician is__ or is not__ an owner of this surgery center. I received this information prior to the date of admission. I understand that I am free to choose another facility in which to receive the services that have been ordered by my physician.
ADVANCE DIRECTIVE/LIVING WILL: I understand that if an emergency medical condition should occur I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an advance directive or living will, the surgery center will still transfer me to the closest hospital which will make decisions about following any advance directive or living will. ***If I should be transferred to a hospital, I consent to the hospital to release copies of my medical records to the surgery center to review the episode of care*.**

I have the following	**Copy given to Surgery Center**
☐ Living Will	☐
☐ Health care surrogate, proxy, or durable power of attorney	☐
☐ Power of Attorney	☐

FINANCIAL AGREEMENT: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the surgery center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the Center's charges (including but not limited to insurance companies, health care service plans or worker's compensation carriers). Whether signing as the patient or his/her agent, I agree that in consideration of the services rendered, I shall be individually responsible to pay the Center for all services, at the Center's regular rates and terms should my insurance company deny payment. I understand the fees quoted are only an estimate. If any additional procedure(s) are added or special supplies/implants are used I will be billed accordingly. I shall also be responsible for any deductibles or co-payments owed at the time of services. I am responsible for payment within 60 days of the date of the service provided unless there is a contract the surgery center has signed with my insurer that states otherwise. Should my account be referred for collection to an attorney, collection agency or other collection service, I agree to pay the costs of collection, including but not limited to attorney fees, court costs and other reasonable collection fees as may be needed. Additionally, interest at the rate of 1.5% monthly or 18% annually may be charged until my financial obligation is paid in full. I shall be responsible for paying the Center interest on the full outstanding balance at the maximum rate allowed by law. I hereby certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act or by any other payor is correct. I assign to the Surgery Center all benefits due me under the terms of said policies and programs but not to exceed the Center's regular charges for similar services. **I authorize payment of medical benefits to the surgery center for the services provided.**
PATIENT PRIVACY, RIGHTS AND REPSONSIBILITIES: I have been provided a copy of the Privacy Notice. I received prior to the date of admission the Patient Rights and Responsibilities statement. I know to whom I can express suggestions and complaints.

I hereby acknowledge.
the above statements.

_____ _____

Patient Signature **Date/Time** **Witness** **Date/Time**

(In the event the patient is a minor, unconscious or is otherwise not competent to acknowledge and understand due to physical or mental conditions, complete the following.)

_____ _____

Patient's Representative **Date/Time** **Witness** **Date/Time**

_____

Representative Name – Print **Relationship**