Musculoskeletal Ambulatory Surgery Center

Location: _____

Name: _____

DOB: _____ Age: _____ Sex: _____

Doctor: _____

MRN#: _____ DOS: _____

Ambulatory Surgery Center Admission Form

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 is the responsibility of the patient's physician to obtain the patient's ill-formed 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 SERVICES: I understand that anesthesia professionals who provide anesthesia services bill separately. I also understand that my physician may have a professional radiology service review radiological images. My physician may also send specimens to a professional pathology laboratory for a pathological diagnosis. Anesthesia, radiology and pathology services are billed separately by those individual physicians and laboratories.

PERSONAL VALUABLES: It is agreed and understood that the surgery center shall not be responsible for any personal property brought by the patient to the surgery center, including but not limited to money, jewelry, 'documents, or any other articles.

OWNERSHIP OF SURGERY CENTER: I have been informed there may be physicians who have ownership in this surgery center. I understand that I am free to choose another facility in which to receive services.

ADVANCE DIRECTIVE/LIVING WILL: I understand that if an emergency medical condition should occur I will be transferred to a hospital for further evaluation and treatment. I understand that if I have an advance directive or living will, the surgery center will not honor any requests not to resuscitate and will still transfer me to a hospital which will make decisions about following any advance directives or living will. **I have the following:** **Copy given to Surgery Center**

[ ] Living will _____ [ ]
[ ] Health care surrogate, proxy, or durable power of attorney _____ [ ]
[ ] Power Attorney _____ [ ]
[ ] Guardianship _____ [ ]
[ ] NONE of the Above _____ [ ]

PATIENT PRIVACY, RIGHTS AND RESPONSIBILITIES: I have been provided a copy of the Privacy Notice, I received a copy of the patient rights and responsibilities statement. I know to whom I can express suggestions or complaints. **If I should be transferred to a hospital or if I am seen at a hospital within a week of my procedure, I grant consent for the hospital to release copies of my medical records to The Surgery Center to review the episode of care.**

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 such 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 they 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 90 days** of the date of the service provided unless there is a contract the surgery center has signed with my insurer that states otherwise. I acknowledge and agree that the Surgery Center and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. Should this account be referred for collection to any attorney or collection agency, I shall pay all attorneys ' fees and collection expenses in connection therewith, if the patient's account is delinquent. 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 XVIII and XIX of the Social Security Act or by any other payer 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.

I also acknowledge I have received and understand the following items prior to the procedure.

- **Patient Rights and Responsibilities**
- **The Surgery Center's policy about advance directives**
- **Physician ownership information**

I hereby acknowledge all of the above statements

_____ _____

Patient Date Time Witness Date Time

(In the event the patient is a minor, unconscious, or is otherwise not competent to acknowledge an understanding due to physical or mental condition, complete the following.) If patient's personal representative, state relationship and authority:

_____ _____

Patient's Representative & Relationship Date Time Witness Date Time

Permission to Verbally Discuss Health Information

In limited cases, we may provide health information to family members, or close friends who are directly involved in your care or the payment for your health care, **unless you tell us not to.** For example, we may tell a friend who asks for you by name where you are in our facility, and we may allow a friend or family member to pick up a prescription for you. We may also contact a family member if you have a serious injury or in other emergency circumstances. We may discuss medical information in the presence of a family member or friend **if you are also present and indicate that it is okay to do so.**

You can give us permission to discuss information about you with family, friends and others you designate who are involved in your care or concerned about your health status and may ask about your condition or need information **when you are not present.** You can tell us who we may talk with about your medical care, including your appointment and scheduling information, lab and test results, treatment information and billing information. This does not mean that the person will have access to your medical records. Permission to disclose or release medical records is handled completely separate.

Complete this form to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information. Here are some examples of when it might be useful to you to release information:

- If you want a relative or friend to help understand medical treatment instructions
- If a relative or friend is helping with billing questions
- If a friend or relative calls to verify an appointment time
- If a relative or friend comes in and asks if you are here and in or out of surgery or the procedure room.

If you change your mind when you have another appointment with us, you can complete a new permission form. You must notify us **IN WRITING of the changes you want.**

I give permission to the Surgery Center to VERBALLY discuss the following information about me (***check all boxes that apply***) with the following person(s)

Name: _____

Address: _____

Phone numbers: Work _____ Mobile _____ Home _____

- ☐ Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan
- ☐ Lab/test results
- ☐ Billing and payment information
- ☐ My location in the facility, whether I have been released and discharged.

I understand that I have the right to revoke my permission at any time except where the Surgery Center has already made disclosures relying upon this permission request. **I understand I must notify the Surgery Center in writing if I want to revoke my permission.**

_____

Signature of Patient/Authorized Representative Date

PLACE RECORD ID STICKER HERE