Premier Surgical Center Facility Consent LABEL

CONSENT TO TREATMENT WITHIN THE FACILITY: I authorize Premier Surgical Center to treat and care for me during my visit. I understand that the Facility maintains personnel and equipment to assist my doctor with surgical operations and other diagnostic or therapeutic procedures. I consent to use the Facility's staff and equipment for my care.

RELEASE OF INFORMATION: I agree that the Facility may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third-party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers, manufacturers required by FDA to track medical devices, or my employer. This includes appropriate release of and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers, when necessary, for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

PATIENT RESPONSIBILITIES: I will provide accurate information about present and past illnesses, hospitalizations, medications, allergies and "NPO" status (when I last had food or fluid). I will make every attempt to understand the implications of my procedure, including risks of refusing treatment, and I will ask for clarification when needed. I will follow all discharge instructions. I will be respectful of the rights and property of other patients and staff. I will remove all jewelry and give it along with any other valuables for safekeeping to the person accompanying me, as the Center is not responsible for my valuables or liable for theft or loss. I will immediately inform my physician of change in condition or adverse reaction. I will play an active role in my pain management.

FINANCIAL AGREEMENT: I agree to pay the Facility in accordance with its regular rates and terms. TERMS: Net 30 days from date of invoice unless otherwise indicated above. Should collection become necessary, the responsible party agrees to pay any additional collection fees, and all legal fees of collection without suit, including attorney fees, court costs and filing fees.

ASSIGNMENT OF INSURANCE BENEFITS: I acknowledge that the insurance information I have provided is accurate and true and I authorize direct payment to the Facility of any insurance benefit. I understand that I am responsible for any charges not paid by my insurer and I agree to pay any unpaid balances on my account no more than 90 days after the date of service.

DISCLOSURE OF OWNERSHIP: The physician who refers you to our Surgical Center may have an ownership interest in this Facility. You are free to choose another facility in which to receive services.

MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I understand that there are several types of advance directives; the two most common forms are living wills and durable power of attorney designation. I understand that in the ambulatory care setting, if I suffer a cardiac or respiratory arrest or other life-threatening situation, signing this document grants consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with Federal law, the Facility is notifying you that it will NOT HONOR previously signed advance directives. I temporarily waive it in its entirety for the duration of my visit at the Facility. If this is not acceptable to you, you must address this issue with your physician and anesthesiologist/anesthetist.

TRANSFUSIONS, EMERGENCIES, TRANSFER AND RIGHTS TO DISCHARGE SUMMARY: In the event of a true life-threatening medical emergency, I authorize the transfusion of blood or blood products. I understand that in the event of an emergency or the need for extended care, I may be transferred to a hospital. If I am transferred, I authorize the Facility to request and obtain a copy of my "Discharge Summary" within 24 hours post-surgery to provide the Facility follow-up information regarding my case.

BLOOD OR BODILY FLUID EXPOSURE: In the rare event that a Facility employee or health professional has accidental exposure to my blood or other bodily fluids (ex. they are stuck with a needle with my blood on it), I authorize the Facility to draw blood for testing the presence of HIV/AIDS or Hepatitis. I know I will not be charged for this testing. If the tests show the presence of these illnesses, the results will be forwarded to my personal physician for confidential medical follow up and treatment if needed to protect my health and the health of my family. Additionally, the Facility will offer medical care to the involved employees or healthcare professionals. All tests will be handled in a strictly confidential manner.

I certify that I have read this document, and am the patient, or am duly authorized to execute it and accept its terms.

_____

Patient Signature Date