



**ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS, & DESIGNATION OF AUTHORIZED REPRESENTATIVE**

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, under any policy of insurance or other health care coverage in which the patient is a covered beneficiary, otherwise payable to me for services, treatments, therapies, including major medical, rendered or provided by the above-named health care provider, including their professional corporations or business entities, including without limitation, if applicable, pathology provider, anesthesia provider, and radiology provider by reason of this admission, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feason insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, including major medical, provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chosen action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Medicare: The undersigned parties do hereby assign, transfer and set over any and all Medicare benefits payable for health services relating to this admission to the above-named health care provider, including their professional corporations or business entities, including but not limited to, if applicable, pathology provider, anesthesia provider, and radiology provider, and hereby authorize said healthcare providers or their corporations to submit claims directly to Medicare for payment on behalf of the undersigned patient. Items not covered by Medicare will be the responsibility of the undersigned financially responsible party.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original. **THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS.**

\_\_\_\_\_  
NAME OF PATIENT

\_\_\_\_\_  
SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE &  
FINANCIALLY RESPONSIBLE PARTY

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE

PATIENT LABEL HERE



## AUTHORIZATIONS & DISCLOSURES

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These AUTHORIZATIONS & DISCLOSURES MUST BE SIGNED BY THE PATIENT, or by the party legally and financially responsible for a minor or physically or mentally incapacitated patient. PLEASE READ EACH AUTHORIZATION CAREFULLY.

**AUTHORIZATION FOR MEDICAL TREATMENT:** I hereby authorize any anesthesia, medical or surgical treatment, including services rendered or provided under the general and special instructions of my attending physician, his/her assistants, and other practitioners associated, as may, in their professional judgment be deemed necessary or beneficial for the purposes of diagnosis, treatment and medical care at Advanced Regional Surgery Center. NO PROMISE, GUARANTEE OR WARRANTY HAS BEEN MADE REGARDING THE RESULTS OF ANY MEDICAL TREATMENT OR SURGICAL PROCEDURE. Any and all removed organs, or parts may be disposed of in accordance with accepted medical practices.

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR REIMBURSEMENT:** For purpose of reimbursement, Advanced Regional Surgery Center and each attending or treating practitioner, including, but not limited to, pathology, anesthesia, radiology and laboratory providers, are hereby authorized and directed to disclose all or any part of the medical record for this admission to my employer, insurance companies, other organizations, third party payors, or agencies as may be necessary to verify or process any and all claims for insurance coverage or third party reimbursement. I understand that such disclosures may contain information which could result in limitation or denial of insurance benefits or third-party reimbursement or which could otherwise be harmful or prejudicial to my interests.

**AUTHORIZATION TO RELEASE MEDICAL AND PAYMENT INFORMATION TO SPECIFIC INDIVIDUALS:** Advanced Regional Surgery Center and each attending or treating practitioner are hereby authorized and directed, during my period of this admission, to disclose medical and payment information to my spouse, children, parents, and any other person authorized to consent to treatment pursuant to current state law, concerning my health status, diagnosis, prognosis, and progress.

Advanced Regional Surgery Center is also hereby authorized and directed to disclose and discuss matters related to billing and payment after the period of admission. I do hereby release and hold Advanced Regional Surgery Center, its officers, directors, agents, employees, and all examining and treating practitioners harmless of and from any and all costs, loss damage, or liability resulting from or arising out of such disclosures.

I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care to whom medical and payment information may be released:

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\_\_\_\_\_ Please do not release my medical or payment information to any individuals.

**RELEASE OF RESPONSIBILITY FOR VALUABLES:** Advanced Regional Surgery Center is hereby fully released of and from any and all responsibility for loss or damage to my personal property, money, or valuables.

**NOTICE OF PRIVACY PRACTICES:** I am aware of my rights to privacy of personal health information, under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and am aware that a copy of these rights is available to me upon request.

**RIGHTS AND RESPONSIBILITIES:** I acknowledge that I have received, prior to my procedure, a copy of the Patient Rights and Responsibilities, which includes information regarding where and how I can file a grievance or complaint.

**PHYSICIAN OWNERSHIP DISCLOSURE:** Advanced Regional Surgery Center provides services only to patients admitted by private practitioners who are members of the Medical Staff, some of whom retain joint ownership of the surgery center. I understand I may choose another facility for the services I require, and have elected to receive care at Advanced Regional Surgery Center.

**TRANSPORTATION RELEASE:** I understand that the anesthetic to be administered to me may have effects that make it hazardous for me to drive a car or otherwise travel alone to my home following my procedure and discharge. I have arranged for transportation with a responsible adult to my home and will be under the supervision of a responsible adult for 24 hours following my procedure. I understand that Advanced Regional Surgery Center will not perform my scheduled procedure unless these arrangements are met, and have provided Advanced Regional Surgery Center with my designated responsible party's name and phone number. The responsible party agrees to assume responsibility for accompanying and transporting the named patient to his/her home.

Responsible Party Name

Signature

Phone Number

**NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES:** I have received information about the Advanced Directives Policy at Advanced Regional Surgery Center and I understand that the center policy (regardless of the contents of any advance directive or instructions from a health care surrogate attorney in fact) is to initiate resuscitative measures, should an adverse event occur during my procedure. I would be transferred to the closest acute care facility for further evaluation, where further treatment or withdrawal of treatment measures already begun will be ordered in accordance with my wishes, advance directive or health care power of attorney. My agreement with this policy does not revoke or invalidate any current health care directive or health care power of attorney. Please check one of the following:

- YES, I brought my Advanced Directive/Living Will/Health Care Proxy with me to place a copy in my chart as part of my medical record
- YES, I have an Advanced Directive/Living Will/Health Care Proxy, but did not bring it with me
- NO, I do not have an Advanced Directive/Living Will/Health Care Proxy
- I wish to have information on how I can obtain an Advanced Directive/Living Will/Health Care Proxy

**NOTICE OF FINANCIAL RESPONSIBILITY:** I understand that I am financially responsible to Advanced Regional Surgery Center for any and all charges associated with the services rendered by Advanced Regional Surgery Center, whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. Advanced Regional Surgery Center verifies insurance benefits, however exact coverage and benefits cannot be determined until the claim is received and reviewed by my insurance carrier. I understand this is not a guarantee of payment from an insurance carrier, and all benefits are subject to the conditions and limitations of the plan and are subject to change. I understand that I am financially responsible for charges not covered by an assignment of benefits, or for charges which the insurance carrier declines to pay. When a health plan denies some or all of the charges, Advanced Regional Surgery Center will pursue the internal appeals provided by the health plan, and will only bill the patient for any amounts which remain outstanding after the appeals are exhausted. I further acknowledge:

1. Advanced Regional Surgery Center may be a non-participating provider with my insurance plan, the status of which I have been informed of, and I have chosen to obtain services at this facility.
2. Advanced Regional Surgery Center bills both patients and health plans using the same fee schedule, and my financial obligation is based on my applicable benefit levels associated with services for which Advanced Regional Surgery Center will bill my health plan pursuant to an assignment.
3. Where contractual rates do not apply, patients and health plans are offered discounts based on the time of payment, in accordance with the Advanced Regional Surgery Center Financial Policies, a copy of which is available to me upon request, and has also been made available to my health plan.
4. I am aware of my right to request a complete written estimate of the anticipated charges, and my associated financial responsibility. I understand that the fee quoted to me for the surgery facility is an ESTIMATE only, and it is possible that I will receive a bill for any balance which I remain financially obligated to pay.
5. Fees for anesthesia services, physician fees, pathology services, laboratory fees, durable medical equipment and surgical assistants, or other services rendered which are not included in the facility global rate will be billed separately where applicable.
6. When a payment is received by the patient, directly from the health plan they have assigned to Advanced Regional Surgery Center, patient must endorse and forward the payment and Explanation of Benefits to Advanced Regional Surgery Center as soon as the payment is received to avoid additional financial liability.

**MEDICARE CERTIFICATION AND AUTHORIZATION:** Each of the undersigned certifies that the information given in applying for payment under Title XVII of the Social Security Act, if applicable, is correct. Any holder of medical or other information about the patient pertaining to this admission, is authorized by the Social Security Administration as applicable, or their intermediaries or carriers, any information needed for any Medicare claim and to request that payment of authorized benefits be made on the patient's behalf. The Medicare program is authorized to furnish medical or other information needed for any Medicare claim and to request that payment of authorized benefits be made under Title XVII as necessary to process any complimentary coverage claim.

**THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS.**

\_\_\_\_\_  
NAME OF PATIENT

\_\_\_\_\_  
SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE &  
FINANCIALLY RESPONSIBLE PARTY

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE



**ADVANCE DIRECTIVE and PATIENT RESPONSIBILITY ACKNOWLEDGEMENT**

I understand that I have the right to make choices regarding life-sustaining treatment (including resuscitative measures). If I desire to exercise this right, I understand that I must inform my physician of my wishes. I understand that if I have a Living Will, Durable Power of Attorney, and/or Advance Directive, I must inform Advanced Regional Surgery Center. I am aware that in the event of a life-threatening emergency, it is the policy of Advanced Regional Surgery Center, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, to initiate resuscitative or other stabilizing measures. If an adverse event should occur during treatment at this facility I will be transferred to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with my wishes, Advance Directive, or Health Care Power of Attorney. My agreement with this facility's policy will not revoke or invalidate any current Health Care Directive or Health Care Power of Attorney.

- I decline to implement an Advance Directive
- I would like to implement an Advance Directive and I have given Advanced Regional Surgery Center a copy of such directive.
- I have been given the opportunity to receive a copy of the Privacy Notice (HIPAA)
- I have been informed of my Patients' Rights and Responsibilities and a copy has been made available to me.

I understand that I may revoke this consent at any time by notifying Advanced Regional Surgery Center, in writing, but if I revoke my consent, such revocation will not affect any actions that Advanced Regional Surgery Center took before receiving my revocation.

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of patient or patient's representative

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date



360 Missouri Avenue 19A, Suite 102 / Jeffersonville, IN 47130 / 812-722-1480

Date: \_\_\_\_\_  
To: Out of Network Members  
Re: Non-Participating Provider Agreement  
Patient: \_\_\_\_\_  
Account: \_\_\_\_\_

It is the intention of Advanced Regional Surgery Center, LLC to extend **"In-Network Benefits"** to all of our patients. Your insurance company will pay Advanced Regional Surgery Center, LLC as a non-participating provider and it is our intention to honor their payment **without additional cost to you** than if we were a participating or "In-Network" provider.

It is possible that the insurance payment for your visit to Advanced Regional Surgery Center, LLC will be sent directly to you.

***In the event that the payment is sent directly to you***

- ***Please endorse the check over to the center and***
- ***Mail the check to the center in the self-addressed envelope that the center has provided.***
- ***Please include the Explanation of Benefits (EOB) that you will receive from your insurance provider***

By forwarding the payment, if received, from your insurance provider directly to the center, you avoid the possibility of additional costs for using the facility. Compliance with this request will allow the center to process the payment to your account quickly, efficiently and to make any necessary adjustments without the need to bill you for services due to non-payment. If you receive a payment directly from your insurance provider and do not forward it, the center will attempt to contact you to retrieve it so that your account can be closed.

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Patient/Responsible Party

Date

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Witness

Date

*Pt Label*



**NOTICE OF PRIVACY PRACTICE** as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Effective April 14, 2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Advanced Regional Surgery Center, LLC (ASC) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about the privacy practices at ASC, please see the contact information at the end of this document.

**I. HOW ASC MAY USE OR DISCLOSE YOUR HEALTH INFORMATION**

ASC collects and protects the privacy of your health information. The law permits ASC to use or disclose your health information for the following purposes:

1. **TREATMENT:** ASC may use your health information to provide you with medical treatment or services. For example, information obtained from you by a front office personnel or nurse is necessary to determine what treatment you should receive.
2. **PAYMENT:** ASC may use and disclose health information about you for payment for treatment and services you receive. For example, your health information may be sent to a third party payer such as an insurance company or health plan in order for ASC to receive payment for services rendered.
3. **HEALTHCARE OPERATIONS:** ASC may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and other to evaluate the performance of our staff, assess the quality of care and outcomes in your case and similar cases, and to determine how to continually improve the quality and effectiveness of the health care we provide.
4. **INFORMATION PROVIDED TO YOU AND ON YOUR AUTHORIZATION:** You may give ASC written authorization to use or disclose your health information.
5. **NOTIFICATION AND COMMUNICATION WITH FAMILY:** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
6. **REQUIRED BY LAW:** As required by law, ASC may use and disclose your health information. For example, ASC may disclose health information for the following reasons; judicial and administrative proceedings, to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes; to the Department of Health and Human Services to determine if we are in compliance with federal laws; or to appropriate persons in order to prevent or lessen a serious and imminent threat to the public or safety of a particular person or the general public.
7. **PUBLIC HEALTH:** As required by law, ASC may use and disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; to aid with disaster relief, and reporting disease or infection exposure.
8. **HEALTH OVERSIGHT ACTIVITIES:** ASC may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure, and other proceedings.
9. **DECEASED PERSON INFORMATION AND ORGAN DONATIONS:** ASC may disclose your health information to coroners, medical examiners, funeral directors, or to organizations involved in procuring, banking or transplanting organs and tissues.
10. **RESEARCH:** ASC may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.

11. **WORKER'S COMPENSATION:** ASC may disclose your health information as necessary to comply with worker's compensation laws.
12. **MARKETING:** ASC may contact you to give you information about treatments or health –related benefits and services that may be of interest to you.
13. **GOVERNMENT FUNCTIONS:** Specialized government functions such as protection of public officials or reporting to various branches of the armed services may require use or disclosure of your health information.
14. **APPOINTMENTS:** ASC may use you information to provide appointment reminders by telephone, email or postal service.
15. **BUSINESS ASSOCIATES:** We work with other businesses to help ASC operate successfully. We may disclose your health information to these business associates so that they can perform the tasks we hired them to do. Our business associates must guarantee us that they will respect the confidentiality of your personal health information.

## **II. WHEN ASC MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION**

Except as described in the Notice of Privacy Practices, ASC will not use or disclose your health information without your written authorization.

## **III. YOUR HEALTH INFORMATION**

1. You have the right to request restrictions on certain uses and disclosures of your health information. ASC is not required to agree to the restrictions that you request.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location. Request must be made in writing detailing the alternative methods chosen and could be applicable to fees.
3. You have the right to inspect and/or obtain a copy of your health information for a reasonable fee.
4. You have the right to request that ASC amend your health information that is incorrect or incomplete. ASC is not required to change your health information and will provide you information about the denial process.
5. You have the right to receive and accounting or disclosure of your health information made by ASC except that ASC does not have to account for the disclosure described in treatment, payment, healthcare operation, and government functions of section I of this notice. The first accounting of disclosures within a twelve-month period is free. Any additional accountings in that time frame are subject to a fee.
6. You have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
7. You have the right to obtain a paper copy of this Notice upon request.
8. You have the right to be notified in the event of a breach in ASC's patient information.
9. You have the right to request that your health plan not be informed of your treatment at ASC if you pay in full and your insurance company is not billed.

## **IV. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES**

ASC reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, ASC is required by law to comply with this notice. A paper copy of this notice is available if you request a copy.

## **V. COMPLAINTS**

If you believe that your privacy rights have been violated or if you have complaints about this Notice of Privacy Practices, contact the ASC Administrator at:

Advanced Regional Surgery Center  
360 Missouri Ave Ste 102, 19A  
Jeffersonville, IN 47130  
Phone: 812-722-1480 Fax: 812-288-2160



If you are not satisfied with the manner in which ASC handles a complaint, you may submit a formal written complaint to the Department of Health and Human Services, Office for Civil Rights. You will not be retaliated against for filing a complaint.