CONSENT FOR ADMISSION AND TREATMENT
AUTHORIZATION TO RELEASE INFORMATION
ACKNOWLEDGEMENT AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION
ACKNOWLEDGEMENT OF RIGHTS AND RESPONSIBILITIES
ACKNOWLEDGEMENT OF DISCLOSURE OF OWNERSHIP

I, as patient (or as agent or personal representative of the patient), authorize the admission to Flatirons Surgery Center (FSC) for outpatient care and treatment. I authorize and consent to the administration of all routine and emergency treatment; procedures and medications which the physician(s) responsible for diagnosis and treatment feel are necessary or desirable. Flatirons Surgery Center maintains personnel and facilities to assist my physician and surgeon in their performance of various surgical operations and other special diagnostic and therapeutic procedures. These surgical operations and special diagnostic or therapeutic procedures all involve RISKS OF COMPLICATIONS, SERIOUS INJURY, OR EVEN DEATH, from both known and unknown causes. I understand that except in emergency or extraordinary circumstances, consent will be obtained from or on my behalf before performance or administration of substantial procedures. My physician is an independent contractor who has been granted the privilege of using FSC for the care and treatment of his/her patients.

Assignment of Insurance Benefits and Authorization to Release Information. I hereby assign FSC all right and title and interest of any payment due for services described herein as provided in the policy or policies of insurance below.

Medicare patient's Certification Authorization to Release Information and Payment Request: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorized any holder of medical or other information about me, the Social Security Administration or its intermediaries or carriers to release any information needed for this or a related Medical Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment on my behalf.

PLEASE READ THE FOLLOWING CAREFULLY, YOU AUTHORIZE FLATIRONS SURGERY CENTER TO ACT ON YOUR BEHALF.

1. I authorize FSC to release information and copies of medical records concerning my diagnosis and treatment to third party payers and their agents and legal representatives, and to other third parties who may be obligated for payment of the medical expenses incurred by me. Medical records may be used for clinical continuation of care purposes, if applicable. For the purpose of the authorization which I have granted, I hereby waive any right to confidentiality of my medical records which I may have, and I hereby release the Flatirons Surgery Center from any claims or liability for release of medical records and information pursuant only to the authorization I have granted.

2. I authorize and consent to those routine tests deemed necessary by FSC to ensure proper diagnosis for those health care professionals who may accidentally incur a potentially infectious exposure from me in the course of my care. These tests may include HIV, Hepatitis or other infectious diseases that spread through body fluid contact.

3. Our team is dedicated to delivering the highest quality care in a safe environment that places the patient at the center of our care. The majority of procedures performed at FSC are considered to be minimal risk. It is, therefore, the policy of FSC that if an adverse event occurs during your treatment, the medical team will initiate resuscitative or other stabilizing measures to transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive or health care power of attorney.

4. In the event that I should need blood products, (packed blood cells, platelets, plasma, whole blood), I authorize and consent to the administration of the blood products my physician feels is most appropriate. I acknowledge that receiving blood products carries some risk.

5. I acknowledge that I have received the FSC privacy notice and the FSC Patient Rights and Responsibilities. I understand that my personal health information may be used for the purposes of healthcare operations, treatment and payment activities. I understand that FSC is not responsible for items lost or stolen during my stay here.

6. I acknowledge that I have received notice of all physicians who have ownership interest in Flatirons Surgery Center.

7. **Statement of Financial Liability**: I understand that I am responsible for the full payment of the bill and the fact that I have assigned insurance benefits does not relieve my obligation to pay in full. Unless other payment arrangements have been made in writing, any outstanding balance will be due 90 days from the date of service. If a Collection Agency is required to collect payment for this account, any legal fees incurred, will be the responsibility of the patient. Patients without insurance coverage will be expected to pay for services on the day of the surgery. **All payments collected on the date of surgery are based upon estimates only. Additional charges may apply.** These additional charges may include implants that are deemed necessary for your procedure by your surgeon. It is not possible to provide estimates of these implants prior to surgery. I understand that any charges from the Surgeon, Anesthesiologist, Surgical Assistant, Pathologist and/or laboratory required for this surgery, are not billed for, or collected by, Flatirons Surgery Center. *FSC is not responsible for network contracts or lack thereof between the above stated providers and the Patients insurance provider.* _______ (witness initials)

THE ABOVE HAS BEEN READ AND UNDERSTOOD AS INDICATED BY MY SIGNATURE BELOW.
I have spoken to my surgeon regarding the procedure that is to be performed today and certify that I understand and agree with the treatment plan.

PATIENT/AGENT SIGNATURE ______________________________ Date: __________ Time: __________

WITNESS TO SIGNATURE ______________________________ Date: __________ Time: __________

FEDERALLY MANDATED CONDITIONS FOR COVERAGE
PATIENT RIGHTS AND RESPONSIBILITIES

ADVANCED HEALTHCARE DIRECTIVES, also known as advance directives, are instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity. If you already have an Advance Directive, please bring it with you to the surgery center. Although we are a resuscitative facility, your Advance Directive will go with your chart to the hospital, should you be admitted. If you would like an Advance Directive brochure, they will be available at the surgery center.

OWNERSHIP DISCLOSURE:
Flatirons Surgery Center is jointly owned by USPI, PorterCare Adventist Health System, David Bierbrauer MD, William Ciccone MD, Thomas Eickmann MD, Daniel Ocel MD, and Flatirons Surgical Group which includes Melody Denham MD, Andrew Goldman MD, David Grauer MD, Joseph Hsin MD, Thomas Mann MD, David Morrissey MD, James Reid MD, J. Douglas Warren MD, and Michael Wertz MD.

PATIENT RIGHTS:
Patients have the right to be informed of alternative treatments and to choose among the alternatives, including the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of their actions.

Patients have the right to every consideration of privacy concerning their medical care.

Patients have the right to expect that all communications and records pertaining to their care should be treated as confidential.

Patients have the right to examine and receive an explanation of their treatment program from their chosen physician.

Patients have the right to examine and receive an explanation of their bill.

PATIENT RESPONSIBILITIES:
Patients have the responsibility to cooperate in their treatment plan. **It is the patient's responsibility to provide the physicians and staff at the surgery center accurate information both about their health history and physical needs.**

Patients are responsible for their own actions if they refuse treatment or do not follow the doctor's recommendations.

Patients have the responsibility to provide accurate billing information necessary for claim processing, and to be prompt in payment of their bills. Should the information provided by the patient or patient's agent prove to be inaccurate, the patient will be responsible for immediately paying the charges in full.

If at any time you believe you are not being treated in a fair and concerned manner, please notify the Administrator at 720-890-2721.

Or you may contact the Medicare Beneficiary Ombudsman at www.medicare.com/ombudsman or the Colorado Department of Public Health and Environment at:

4300 Cherry Creek Dr. South
Denver CO 80246
Telephone : 303-692-2000.

Thank you,

The Staff of Flatirons Surgery Center