MARION SURGERY CENTER
AUTHORIZATIONS & DISCLOSURES

These **AUTHORIZATIONS** MUST BE SIGNED BY THE PATIENT (or by the party legally responsible for a minor or physically or mentally incapacitated patient), and by the party financially responsible for the patient, if other than the patient. PLEASE READ EACH AUTHORIZATION CAREFULLY.

1. **AUTHORIZATION FOR MEDICAL TREATMENT:** Each of the undersigned hereby authorize any anesthesia, medical or surgical treatment, and Your Surgery Center service rendered or provided under the general and special instructions of my attending physician, his/her assistants, and other practitioners associated for purposes and diagnosis, treatment and medical care. NO PROMISE, GUARANTEE OR WARRANTY HAS BEEN MADE REGARDING THE RESULTS OF ANY MEDICAL TREATMENT OF SURGICAL PROCEDURE. Any and all removed organs, or parts may be disposed of in accordance with accepted medical practices.

2. **AUTHORIZATION TO RELEASE MEDICAL INFORMATION:**

    a) For purpose of reimbursement: **Marion Surgery Center** and each attending or treating practitioner, including, if applicable, PATHOLOGY, ANESTHESIA, and/or RADIOLOGIST, are hereby authorized and directed to disclose all or any part of the medical record for this admission to my employer, to my insurance companies, and 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. WE 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 (OUR) INTERESTS. Nevertheless, each of the undersigned do hereby release and hold **Marion Surgery Center**, its officers, directors, agents and employees, and all examining and treating practitioners harmless of and from any and all cost, loss, damage, or liability resulting from and such disclosure(s).

    b) To Family and Responsible Party: **Marion Surgery Center** and each attending or treating practitioner, UNLESS SPECIFICALLY INSTRUCTED OTHERWISE BY DELETING THIS SUBPARAGRAPH 2(b), are hereby authorized and directed, during the period of this admission, to disclose information to the patient's spouse, children, parents, and any other person authorized to consent to treatment pursuant to 431.061-.065, RSMO (1979) as amended, concerning the patient's health status, diagnosis, prognosis, and progress. Each of the undersigned do hereby release and hold **Marion 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 disclosure(s).

3. **RELEASE OF RESPONSIBILITY FOR VALUABLES: Marion Surgery Center** is hereby fully released of and from any and all responsibility for loss or damage to the personal property, money, or valuables of the undersigned patient.

4. **NOTICE OF PRIVACY PRACTICES:** I am aware of my rights to privacy of personal health information, under the Privacy Rule of Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**").

5. **PHYSICIAN OWNERSHIP DISCLOSURE: Marion Surgery Center** provides services only to patients admitted by private practitioners who **Marion Surgery Center** are members of the medical staff, some of whom retain joint ownership of the surgery center.

6. **FLAT RATE FEE: Marion Surgery Center** charges a flat rate global fee for surgical services.

7. **TERMS FOR TREATMENT & FINANCIAL RESPONSIBILITY**: I understand that treatment deposit and/or acceptable hospitalization insurance is required for treatment in **Marion Surgery Center**. Total balance is due on the day of surgery, with allowance made for insurance coverage APPROVED AND VERIFIED PRIOR TO TREATMENT. In accordance with above terms, and in consideration of agreement to render treatment and furnish supplies, the undersigned patient and/or **Marion Surgery Center** undersigned surety, do hereby agree upon demand to pay **Marion Surgery Center**, its agents or assigns, whatever the sums of money that shall become due on the account of the patient and that such liability shall be joint and several. It is agreed that if full payment is not made by insurance or other third party payors within thirty (30) days, the undersigned shall make payment in full. ANY PAST DUE BALANCES NOT PAID BY INSURANCE OR OTHER 3RD PARTY PAYER, SENT TO A COLLECTION AGENCY IS THE RESONSIBILITY OF THE GUARANTOR AND HE/SHE AGREES TO PAY **ALL** COLLECTION FEES OR COURT COSTS.

8. **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 to 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.

9. ASSIGNMENT OF INSURANCE AND THIRD PARTY BENEFITS:

a) **To the Surgery Center**: The undersigned, and each of them, do hereby assign, transfer, and set over unto **Marion Surgery Center** all benefits payable to them or either of them now due and to become due and payable, including major medical benefits, by reason of this admission under any policy of insurance or other health care coverage in which the patient is a covered beneficiary. **I further assign to Surgery Center my rights to appeal reimbursement decisions rendered by any and all third party insurers notwithstanding any contractual provisions to the contrary between myself and my insurers**.

b) **To the Health Care Provider**: The undersigned parties do hereby assign, transfer, and set over unto the patient's health care providers, including their professional corporations or business entities, including without limitation, if applicable, Pathology Provider, Anesthesia Provider, and Radiology Provider, all benefits otherwise payable to the undersigned now due and to become due and payable, including major medical benefits, by reason of this Surgery Center admission under any policy or other health care coverage contract in which the patient is a covered beneficiary.

c) **To Medicare**: The undersigned parties do hereby assign, transfer and set over any and all Medicare benefits payable for Surgery Center and health services relating to this admission to **Marion Surgery Center** and to the patient's health care providers, including their professional corporations or business entities, including but not limited to, if applicable, Pathology Provider Name, Anesthesia Provider Name, Radiology Provider Name, and hereby authorize **Marion Surgery Center** and said health care 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.

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

DO NOT sign these authorizations without a full understanding of each.

NAME OF PATIENT	DATE
NAME OF AUTHORIZED REPRESENTATIVE TO DISCUSS ABOVE NAMED PATIENTS MEDICAL AND/OR FINANCIAL ISSUES IN THEIR ABSENCE.	DATE
SIGNATURE OF PATIENT, AUTHORIZED REPRESENTATIVE & FINANCIALLY RESPONSIBLE PARTY — RELATIONSHIP	DATE
WITNESS	DATE