CONDITION OF ADMISSION TO CENTER FOR ADVANCED SURGERY

PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE AGREES TO THE FOLLOWING TERMS:

1. MEDICAL AND SURGICAL CONSENT: The patient is under the control of his/her attending physician and the facility is not liable for following the instructions of such physicians. The patient recognizes that independent contractors, i.e., surgeon, pathologist, anesthesiologist, or laboratory will be submitting separate bills for services rendered to the patient.
2. TEACHING PROGRAMS: Some services may be provided to the patient by persons in training under the supervision and instruction of your physician or facility nursing staff if he participates in a residency program. These persons may also observe care under the directions of your physician or facility nursing staff.
3. MEDICAL RESEARCH: Information may be released for use in medical studies and medical research.
4. WORKER'S COMPENSATION: The facility recognizes that worker's compensation cases are the sole responsibility of the employer's insurance carrier and that the patient is not financially responsible. In the event that the injury is found to be non-work related or otherwise not covered by worker's compensation insurance upon notification of such denial, the patient will be found to be financially responsible. The patient is responsible for initiating form 102 to qualify claim for industrial injury.
5. FINANCIAL AGREEMENT: In consideration of the services rendered to me, I hereby obligate myself to pay the account with the facility. Should the account be referred to an attorney or license collection service, I shall pay reasonable attorney fees and collection expenses. I further acknowledge that I have provided all medical insurance plans at the time of admission and further understand that if I failed to disclose all requested information, I will be held responsible for any expenses incurred at this facility.
6. REIMBURSEMENT UNDER MANAGED CARE CONTRACTS: The facility has special contracts with some insurance companies and other payors to which the reimbursement may or may not have any relationship to charges. The patient or insurance is not required to pay any balance over the contracted rate nor is the patient or insured entitled to a refund in the event of overpayment by the carrier according to the allowable rate.
7. MEDICARE ASSIGNMENT: Center for Advanced Surgery is a participating provider of Medicare. We will accept Medicare assignment. The patient will be responsible for payment of any annual deductible and twenty percent co-insurance not paid by Medicare or secondary insurance carrier.
8. I understand that, as a courtesy, the Center will file my primary and secondary insurance only. After 60 days from the date of service, the total balance will be considered due and payable by the patient.

ASSIGNMENT & RELEASE:

I authorize the release of that part of the record, which is required to submit claims to and collect fees from medical services companies, insurance companies, worker's compensation carriers, welfare funds, or employers. I further authorize any hospital to release pertinent discharge summary/operative report of a transfer/admit to a local hospital as a result of a procedure performed at this facility. I also request payment of government benefits either to myself or to the provider who accepts assignment of benefits. A photostatic copy of this assignment shall be valid as the original. The patient or his/her authorized representative certifies that he/she has read and understands the foregoing, received a copy thereof, and is authorized to execute the above and accept its terms.

Signature of Patient or Authorized Representative	Date	Witness

Check one: ❑ Patient ❑ Insured ❑ Parent of Minor Child ❑ Court Appointed Guardian

ADVANCE DIRECTIVES

A. RECEIPT OF INFORMATION & UNDERSTANDING. THE PATIENT CERTIFIES THAT HE/SHE:

1. Has received a copy of Patient's Rights and understands facility's advance directive policy
2. Has been informed of the facility's grievance process
3. Understands that he/she is not required to have an advance directive before receiving medical treatment

B. PATIENT'S POSITION REGARDING ADVANCE DIRECTIVES:

The patient has elected to execute the following advance directives:

❑ Health Care Power of Attorney ❑ Living Will ❑ Combined Power of Attorney/Living Will ❑ DNR

- ❑ The patient has provided copies of the Advance Directives to be placed in his/her medical record.
- ❑ The patient has not provided copies of the Advance Directives to be placed in his/her medical record.
- ❑ The patient does not currently have an Advance Directive and does not wish to make one at this time.
- ❑ The patient has one on file from previous admission and does not wish to change Advance Directive.

Signature of Patient or Authorized Representative	Date	Witness

Relationship:_____ ❑ Patient Unable to sign medically and/or physically

If DNR is indicated above, Physician reviewed DNR with patient:

Physician Signature:_____ Date: _____

Center for Advanced Surgery complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.