Upper Bay
Surgery Center,LLC

AUTHORIZATIONS & DISCLOSURES

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: The undersigned hereby authorizes 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 [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 purpose of reimbursement, [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. Unless specifically instructed otherwise, [Surgery Center] and each attending or treating practitioner 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 [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.

RELEASE OF RESPONSIBILITY FOR VALUABLES: [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.

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 are 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: [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 [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 [Surgery Center] will not perform my schedule procedure unless these arrangements are met, and have provided [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.

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I have received information about the Advanced Directives Policy at [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:

NOTICE OF FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to [Surgery Center] for any and all charges associated with the services rendered by [Surgery Center], whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. [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, [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. [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. [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 [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 [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 [Surgery Center], patient must endorse and forward the payment and Explanation of Benefits to [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.

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NAME OF PATIENT

_____ _____

SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE & FINANCIALLY RESPONSIBLE PARTY — RELATIONSHIP — DATE

_____ _____

WITNESS — DATE