32nd Street Surgery Center, LLC's

Authorizations and Disclosures

The authorizations noted below *must* be signed and initialed by the patient or authorized representative prior to admission.

_____ **NOTICE OF PRIVACY PRACTICES (HIPAA):** 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 (HIPPA) and that the 32nd Street Surgery Center's Notice of Privacy Practices were made available to me in writing.

_____ **PHYSICIAN OWNERSHIP DISCLOSURE:** Your physician may have a financial interest in this facility. 32nd Street Surgery Center LLC services only patients admitted by private practitioners who are credentialed members of the 32nd Street Surgery Center LLC 's medical staff, some of whom retain joint ownership of the surgery center.

_____ **ASSIGNMENT OF INSURANCE & 3rd PARTY BENEFITS**: I hereby authorize and request my insurance company to pay directly to the 32nd Street Surgery Center all benefits due now and to become due me for medical benefits under this claim.

_____ **ASSIGNMENT OF APPEAL REPRESENTATIVE**: I hereby designate the 32nd Street Surgery Center, or its representatives, as my appeal representative in connection with this claim. I understand that my insurance will disclose PHI to the designated person in connection with this appeal. I also understand that the 32nd Street Surgery Center may appeal this claim for a reduction of usual and customary charges.

_____ **MEDICARE/CERTIFICATION AUTHORIZATION**: I certify that the information given in applying for payment under the Title XVII of the Social Security Act, if applicable, is correct.

_____ **RELEASE OF RESPONSIBILITY FOR VALUABLES**: I understand I was instructed to leave all valuables at home. I understand all valuables brought to the center are given to my responsible adult or secured by center staff. I hereby fully release the 32nd Street Surgery Center of and from any and all responsibility for loss or damage to the personal property, money, or valuables of the patient.

_____ **FINANCIAL POLICY**: I understand that a deposit and/or acceptable hospitalization insurance is required for treatment at 32nd Street Surgery Center. The total amount is due on the day of surgery, with allowance made for insurance coverage *verified prior to treatment.* I also acknowledge that 32nd Street Surgery Center provided me a copy of the "Financial Policy" prior to Today's visit. **COPAY/ CO-INSURANCE DUE TODAY**: $_____. This is an estimate based upon my insurance coverage deductible and co-pay/co-insurance for ONLY the facility fees, based on the proposed treatment. However, if the procedure varies from what was scheduled or benefits differ from what was verified, I may incur additional charges.

_____ **MO/KS MEDICAID**: I understand that if I have not met my "spend down" at the time of treatment and the payment received by the Center has been reduced by that amount I will be liable for the difference.

_____ **OUTSIDE SERVICES**: I am aware that I may be billed for additional services including but not limited to: my physician, anesthesia services and laboratory services.

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_____ **PATIENT RIGHTS:** I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure.

_____ **ADVANCE DIRECTIVES**: I have received information regarding 32nd Street Surgery Center's policies pertaining to ADVANCE DIRECTIVES prior to the procedure. Information regarding Advance Directives, along with applicable state forms are available for me upon request.

Please review and *initial* those that apply.

___ *(Initial)* I have an Advance Directive and have provided a copy to the surgery center.

___ *(Initial)* I have an Advance Directive but did not bring a copy of my Advance Directive to the surgery center. I am willing to proceed with my procedure without having my Advance Directives as part of my medical record.

- My Advance Directive is a _____, a copy can be located at_____.

___ *(Initial)* I do not have Advance Directives, but have been informed and have been offered the applicable Missouri forms.

By signing below I certify that I have read and understand each of the above authorizations.

_____ _____

Patient or Authorized Representative's Signature **Date**

_____

Relationship to Patient

_____ _____

Witness **Date**

Revised 3-1-16