TUCSON
Surgery Center

Consent to Treat Form

- I, the undersigned, am the patient or patient's duly authorized representative and do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic treatments considered to be advisable in the judgment of the attending physician, his/her associates or designees.
- I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of procedures or surgery performed at this facility.
- I understand I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw consent for treatment or tests prior to being performed.
- I am aware that services may be performed by independent contractors who are not employed by the facility.
- I understand and acknowledge that I am responsible for the safekeeping of any of my personal belongings such as cash, jewelry and credit cards while I am at the facility.
- I understand and agree not to photograph, video tape, record or otherwise capture imaging or sound on any device during my time at this facility. I also understand it is my responsibility to assure my visitors comply with this requirement.
- I consent to have my blood drawn and tested for diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood.
- I consent to the presence of observers for regulatory surveys, quality, clinical, and/or educational purposes.
- I understand that I am going home after surgery and that I must have a responsible adult to drive me home and take care of me, unless otherwise instructed by my physician.
- I voluntarily consent to have my surgery/procedure done at this facility.

ACKNOWLEDGEMENT

The undersigned certifies that he/she has read (or had read to me) the foregoing, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms. I understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative			Date/Time
Relationship to Patient		Interpreter, if Utilized	Date/Time
Witness Signature	Date/Time	If Telephone Consent, Second Witness Signature	Date/Time

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Assignment of Benefits Form

Name of Insured: ______________________ DOB: ______________

Policy Holder: ______________________ DOB: ______________

Relationship to the Patient: ______________________ Employer: ______________

Insurance Carrier: ______________ ID#: ______________ Group#: ______________

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organizations listed below for any equipment or services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, my insurance carrier or other medical entity.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits.

It is my responsibility to notify the organization of any changes in my health care coverage. In come cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

In conjunction with the assignment of benefits I also hereby authorize the organization to appeal to the above mentioned insurance company on my behalf, as my Designated Representative, and as part of the appeal, I hereby authorize the insurance company in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in ALL aspects of the appeal, including copies of the policy guidelines. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

Patient's Signature or Legal Representative			Date/Time
Relationship to Patient		Interpreter, if Utilized	Date/Time
Witness Signature	Date/Time	If Telephone Consent, Second Witness Signature	Date/Time

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Financial Agreement

- I understand that it is the patient's responsibility to check with their health insurance company regarding plan benefits. Any estimated co-payments, deductibles, or co-insurance will be requested at the time of service. Please contact your employer or your insurer directly if you have any questions with your insurance coverage.

- I understand that if I do not have insurance, I will be considered self-pay and that payment of the estimated charges, less any applicable self-pay discounts, will be required at the time of service.

- I understand that the Surgery Center does not accept international insurance. Payment of the estimated charges will be required at the time of service. It is the patient's responsibility to submit the claim to the insurance for reimbursement.

- If any payment is subsequently made by your insurance carrier in excess of the balance estimated, I agree that overpayment may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. If the account is not delinquent, we will promptly refund the credit amount to the Guarantor.

- I understand that any amounts quoted are only an **estimate**. We are legally bound to charge based on the final operative note, which may result in additional charges. The estimate is provided as courtesy only.

Patients initials __________

- I understand that the estimate provided from the Surgery Center is for the facility fee **only**.

- If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs, and attorney's fees.

- I understand that if a check is returned unpaid, a $30.00 service charge will be applied.

- I understand that in addition to surgery center fees, depending on services rendered, I may receive additional bills for other professional services which may include, but not be limited to: **pathology, laboratory, anesthesia services, physician office, physical therapy, and rehabilitation equipment**.

- I understand that I have the right to an itemized bill.

ACKNOWLEDGEMENT

The undersigned certifies that he/she has read (or had read to me) the foregoing, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms. A copy of this statement is availble upon request.

Patient's Signature or Legal Representative			Date/Time
Relationship to Patient		Interpreter, if Utilized	Date/Time
Witness Signature	Date/Time	If Telephone Consent, Second Witness Signature	Date/Time

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Acknowledgement of Required Disclosures Form

I acknowledge that I have reviewed the following information prior to my procedure:

- Patient Rights and Responsibilities in writing
- Complaint/Grievance Process and Contact Information
- CMS rights were verbally reviewed
- The Center's policy on Advance Directives

  Please initial the following applicable statement:

  _________ I have executed an Advance Directive and have supplied a copy to the facility

  _________ I have an executed Advance Directive which is located: ______________________________

  _________ I have not executed an Advance Directive. I have requested a copy of the States Advance Directive Forms

  _________ I have not executed any Advance Directives, and I do not wish to receive information about Advance Directives from this facility

- Advance Directive Forms, if requested
- Disclosure of Physician Ownership and a list of physicians who have a financial interest or ownership in the center, if applicable
- Notice of Privacy Practices Form:

  Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPPA), I acknowledged that I have been offered a copy of the Facility's Notice of Privacy Practices. This will include disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during treatment at the Center.

______ I do not wish for any information regarding my Personal Health or Medical Records to be shared.
(Initial)

OR

______ I allow my Personal Health or Medical Records to be shared with: ______________________________________
(Initial)

I acknowledge that I have:

______ been offered and refused a copy of Tucson Surgery Center Patient Rights and Responsibilities, Advance
(Initial) Directive Policy, Disclosure of Physician Ownership and Notice of Privacy Practices.

______ received a copy of Tucson Surgery Center Patient Rights and Responsibilities, Advance Directive Policy,
(Initial) Disclosure of Physician Ownership and Notice of Privacy Practices.

Patient's Signature or Legal Representative	Relationship to Patient	Date/Time