TURNER SURGERYCENTER

Turner Surgery Center Financial Agreement

RELEASE OF INFORMATION: I agree that the Facility may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers, manufacturers required by FDA to track medical devices, or my employer. This includes appropriate release of and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the Facility, my personal health information will not be disclosed unless I agree to disclosure.

FINANCIAL AGREEMENT: I agree to pay the Facility in accordance with its regular rates and terms.
TERMS: Net thirty (30) days from date of invoice unless otherwise indicated above. Should collection become necessary, the responsible party agrees to pay any additional collection fees, and all legal fees of collection without suit, including attorney fees, court costs and filing fees. I have been informed and understand the facility fee is separate and in addition to other fees I may incur including the professional fee from my surgeon, anesthesia and pathology.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize direct payment to the Facility of any insurance benefit. I understand that I am responsible for any charges not paid by my insurer and I agree to pay any unpaid balances on my account no more than ninety (90) days after the date of service.

DISCLOSURE OF OWNERSHIP: The physician who refers you to our Facility may have an ownership interest in this Facility. You are free to choose another facility in which to receive services. You were informed of this relationship both in writing and verbally prior to the surgical procedure _____ **(Please initial)**

MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVE: I understand that there are several types of advance directives; the two most common forms are living wills and durable power of attorney designation. All patients have the right to participate in their own healthcare decisions and to make advance directives or execute Powers of Attorney that authorize others to make decisions on their behalf based on the patients expressed wishes. This Facility will honor the intent of the advance directive to the extent permitted by law and subject to the limitation of the basis of conscience. This Facility performs elective procedures that generally enhance or improve the patient's quality of life; therefore in the event of a medical emergency, it is the policy of this Facility to initiate resuscitative measures and transfer you to a hospital for further evaluation. At the hospital, further treatments or withdrawal of treatment measures may be exercised in accordance with your Advance Directive or Power of Attorney. I acknowledge that I have read the Advance Directive policy statement prior to the surgical procedure _____ **(Please initial)** this policy applies to all patients having a procedure performed at this facility.

PHONE MESSAGE CONSENT I acknowledge and agree that Turner Surgery Center and any affiliates or vendor thereof, including collection or billing companies, may contact me by email, telephone or text message to any telephonic number or email address I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Turner Surgery Center if I have given up ownership or control of any such telephone number.

HIPAA PRIVACY NOTICE: I acknowledge that I have received the Facility's HIPAA Privacy Notice and have had the opportunity to review its content. _____ **(Please initial)**

PATIENT BILL OF RIGHTS: I acknowledge that I have received my Patient Rights in writing and that my Patient Rights were verbally explained to me prior to the surgical procedure. _____ **(Please initial)**

I certify that I have read this document, and am the patient, or am duly authorized to execute it and accept its terms.

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(Patient Signature) **(Date)**