CENTER OF SURGICAL EXCELLENCE

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Conditions of Service

General Consent to Care: I consent to medical care and treatment as ordered by my physician. My consent includes all facility services, diagnostic procedures and medical treatment rendered including, without limitations, examinations, x-rays, laboratory procedures and other tests, treatments and medications, electrocardiograms and all other procedures that do not require my specific informed consent. I further understand that the physicians who provide treatment to me while I am here are not employees of the facility. I realize these physicians will likely produce a bill for services that are separate from the facility's bill. I am aware that some physicians may not participate in the health plan or payment program that pays for my care and, thus, I may be subject to additional or out-of-network charges.

Physicians providing services here have a financial interest in this facility.

Valuables: I understand and agree that the facility assumes no liability for any loss or damage to any money, jewelry, documents, or other articles brought by or for me to the facility.

Use or Disclosure of Protected: I consent to the use or disclosure of my protected health information for the purpose of carrying out treatment, payment, or healthcare operations.

Assignment of Insurance Benefits and Guarantee of Payment: I hereby assign and consent to payment directly to the facility, of any facility benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third-party organization, otherwise payable to the patient unless the account for this facility is paid in full upon discharge or completion of treatment.

In accordance with these conditions and in consideration of the facility's agreement to furnish services and supplies to the patient, the undersigned, whether signing as patient or as an agent, agrees to pay upon demand to the facility or its agents, whatever sums of money shall become due on the account of the patient. This consent is valid for the length of time necessary to process claims for facility charges. If the account should be turned over to a collection agency for collection, the undersigned shall pay the balance on the account.

Advance Directives: In order to be in compliance with the Self-Determination Act (PSDA) and State law and rules regarding advance directives, the Facility requires each patient prior to scheduled procedures to read and acknowledge the Facility position on advance directives. In the event of a medical emergency or other life-threatening situation, resuscitation will be instituted in every instance and patients will be transferred to a higher level of care. Any previously formulated advance directive will not be honored at the facility. If for any reason you disagree with this policy, please discuss your concerns with your physician before your scheduled procedure.

Health Information Privacy Notice: I have received a copy of the Health Information Privacy Notice. I understand that the Health Information Privacy Notice describes the uses and disclosures of my protected health information by the facility and informs me of my rights with respect to my protected health information.

I certify that I have read this entire document and I am the patient, or I am duly authorized by the patient or by the law to execute the above agreement and accept and understand its terms.

_____ _____

Patient/Legal Representative Date

_____ _____

Witness Date