CORONADO SURGERY CENTER
SURGERY CENTER ADMISSION AND FINANCIAL AGREEMENT

LEGAL RELATIONSHIP BETWEEN SURGERY CENTER AND PHYSICIANS: I understand that all physicians furnishing services to the patient, including the patient's physician, and any specialist such as an anesthesia provider, radiologist, or pathologist are independent contractors with the patient and are not employees or agents of the surgery center. The patient is under the care and supervision of his/her physician and it is the responsibility of the surgery center and its staff to carry out instructions of the physician. It is the responsibility of the patient's physician to obtain the patient's informed consent, to medical or surgical treatment or procedures. Any questions concerning the nature or results of any examination or treatment should be directed to the patient's physician and not to the surgery center employees.
OTHER PROFESSIONAL RELATIONSHIPS: I understand that my physician may have a professional radiology service review radiological images. My physician may also send specimens to a professional pathology laboratory for a pathological diagnosis. Radiology and pathology services are billed separately by those individual physicians and laboratories. I understand that approved company representatives and vendors may be present during my procedure however they will not participate in my procedure. I understand that students may be in attendance during my procedure. Students are under direct supervision of the physician and will not participate in my procedure without direct supervision of my physician.
PERSONAL VALUABLES: It is agreed and understood that the surgery center shall not be responsible for any personal property brought by patient to the surgery center, including but not limited to money, jewelry, documents, or any other articles.
OWNERSHIP OF SURGERY CENTER: I understand that my physician is___ or is not ___ an owner of this surgery center. I received this information prior to the date of admission. I understand that I am free to choose another facility in which to receive the services that have been ordered by my physician.
ADVANCE DIRECTIVE/LIVING WILL: I understand that if an emergency medical condition should occur I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an advance directive or living will, the surgery center will still transfer me to the closest hospital which will make decisions about following any advance directive or living will. ***If I should be transferred to a hospital, I consent to the hospital to release copies of my medical records to the surgery center to review the episode of care.***

I have the following	**Copy given to Surgery Center**
☐ Living will	☐
☐ Health care surrogate, proxy, or durable power of attorney	☐
☐ Power of Attorney	☐

FINANCIAL AGREEMENT: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the surgery center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the Center's charges (including but not limited to insurance companies, health care service plans, or worker's compensation carriers). Whether signing as the patient or his/her agent, I agree that in consideration of the services rendered, I shall be individually responsible to pay the Center for all such services, at the Center's regular rates and terms should my insurance company deny payment. I understand the fees quoted are only an estimate. If any additional procedure(s) are added or special supplies/implants are used I will be billed accordingly. I shall also be responsible for any deductibles or co-payments owed at the time of services. I am responsible for payment within 60 days of the date of the service provided unless there is a contract the surgery center has signed with my insurer that states otherwise. Should this account be referred for collection to any attorney or collection agency, I shall pay all attorneys' fees, court costs and collection expenses at 35% and interest at the rate of 1.5% monthly or 18% annually until the debt is paid. I shall be responsible for paying the Center interest on the full outstanding balance at the maximum rate allowed by law. I hereby certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act or by any other payer is correct. I assign to the Surgery Center all benefits due me under the terms of said policies and programs but not to exceed the Center's regular charges for similar services. **I authorize payment of medical benefits to the surgery center for the services provided.**
PATIENT PRIVACY, RIGHTS AND RESPONSIBILITIES: I have been provided a copy of the Privacy Notice. I received prior to the date of admission the Patient Rights and Responsibilities statement. I know to whom I can express suggestions or complaints.

I hereby acknowledge the above statements.

I also acknowledge that I have received the following items prior to the date of the procedure.
- ☐ Patient Rights and Responsibilities
- ☐ The surgery center's policy about advance directives
- ☐ Physician ownership information

Patient Signature Date Time

Witness Date Time

(In the event the patient is a minor, unconscious, or is otherwise not competent to acknowledge and understanding due to physical or mental condition, complete the following.)

If patient's personal representative, state relationship and authority:

Patient's Representative Date Time

Witness Date Time

CORONADO SURGERY CENTER

HIPAA Acknowledgement

Name_____
(Please Print)

Alternative Communications Request:
At which of the following number(s) do we have permission to contact you?

☐ Home_____ May we leave a message for you at home?
◯Yes ◯No

☐ Cell Phone_____ May we leave a message for you on your cell phone?
◯Yes ◯No

☐ Work_____ May we leave a message for you at work?
◯Yes ◯No

Protected Health Information Restrictions:
Other than you or your insurance company, whom may we talk to about your health care information?

_____ _____ _____
(Name) (Relationship) (Phone Number)

Do you have any health information that you would like to be kept confidential from any person or persons?
◯ Yes ◯ No
If yes, please indicate below the type of information and to whom the restriction applies:

_____

_____

_____

Privacy Notice Acknowledgement:
The patient identified above was provided with a copy of **Coronado Surgery Center's** Privacy Notice and Summary Form.

- I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.
- I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information. I also understand that my protected health information may still be used contrary to my request in the event of an emergency.
- I acknowledge that I have received a copy of the Privacy Notice for **Coronado Surgery Center** Privacy Notice Revision Date: April 14, 2009

_____ _____
Patient or Personal Representative Signature Date

_____
Relationship to Patient

CORONADO SURGERY CENTER
ACCIDENT QUESTIONAIRE

Please complete the requested information for billing. Incorrect billing information will result in full payment responsibility from the patient/ patient representative.

1. Is your procedure because you have an injury from an accident? ☐ **No**-sign and return to front desk **Signature** _____ ☐ Yes-continue to #2
2. Is your procedure because you had a ☐ **car accident**-if yes, go **to Section 1**
   ☐ **work related**-if yes, go to **Section 2**
   ☐ **other type of accident**-go to **Section 3**

SECTION 1: CAR ACCIDENT

Date of accident: _____

1. Have you notified your insurance company?
   ☐ Yes-Name of insurance company _____ Phone # _____
   ☐ No-explain _____
2. Have you contacted a lawyer/attorney? ☐ No

   ☐Yes-Name and contact number:_____
   Is this an Attorney Lien? ○ No ○Yes Is this another lien? If so, with what company and contact number _____

SECTION 2: WORK RELATED

1. Have you notified your employer? ○ No ○Yes Claim # _____ Date of Injury _____
2. Employer Name _____
   Address _____ Phone # _____
   Are you currently working? ○Yes ○ No-last day worked _____
3. Worker's Comp (MCO) Carrier and Adjuster Name _____
   Phone # _____
4. Have you completed an employer's C-3 form? ○Yes ○ No
5. Have you completed a Dr's C-4 form? ○Yes ○ No
6. Is there anything else we should know about this injury or worker's comp claim? If so, please explain _____

SECTION 3: OTHER INJURY

Date of injury _____

1. Type of injury-explain_____
2. Is there insurance coverage for this injury-if so, provide name of company, phone #, claim # _____
3. Has a lawyer/attorney been contacted for this injury-if so, provide name of attorney & phone # _____
4. Has a Med Pay or Attorney Lien been signed-if so, provide contact name and number_____

Patient's Name: **Patient Label**

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that your insurance may not pay for the item(s) or services(s) that are described below. Insurance does not pay for all of your health care costs. Insurance only pays for covered items and services when your insurance company rules are met. The fact that insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Insurance my not pay for-**

Items or Services:
IMPLANTS TO INCLUDE, BUT NOT LIMITED TO: PLATES, SCREWS, CLIPS WIRE, ANCHORS, BONE MATRIX & PRP INJECTIONS. (PROTEIN RICH PLASMA)
Because: THESE ARE SPECIFIC EXCLUSIONS FOR SOME INSURANCE POLICIES. SOME INSURANCE COMPANIES REQUIRE A MINIMUM AMOUNT BEFORE THEY WILL PAY, OTHERS PLACE CAP ON THE AMOUNTS THEY WILL PAY.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why your insurance may not pay.
- Ask us how much these items or services will cost you (Estimated Cost: $50-$1200) in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**
I understand that my insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance is making its decision. If my insurance does pay, you will refund to me any payments I made to you that are due to me. If my insurance denies payment, I agree to be personally and full responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal my insurance companies' decision.
☐ **Option 2. NO I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that insurance won't pay. I also understand with this choice that my surgeon will be notified and my procedure my need to be cancelled.

Date **Signature of patient or person acting on patient's behalf**

Coronado Surgery Center
2779 W Horizon Ridge Parkway, Ste 140
Henderson, Nevada 89052

PATIENT NAME	ACCOUNT NUMBER	DATE OF BIRTH

PATIENT ADDRESS

I HEREBY AUTHORIZE THE FACILITY NAMED ABOVE TO DISCLOSE "PROTECTED HEALTH INFORMATION" TO:

_____
PERSON/ORGANIZATION/FACILITY/HEALTHCARE PROVIDER NAME

_____
STREET ADDRESS

_____
CITY/ZIP CODE

CHECK TYPE OF INFORMATION AUTHORIZED TO BE DISCLOSED
NOTE--Unless the appropriate box is checked, the Facility will only disclose records regarding care and treatment provided in the Facility by Facility staff or its affiliated health care providers.

- ☐ All records/all treatment by all providers/all facilities
- ☐ All records/all treatment from this Facility only
- ☐ Billing Records
- ☐ Physician Progress Notes
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Other:_____
  (Specifically describe the information or date(s) of care/treatment to be disclosed)
- ☐ Physician Orders
- ☐ Nurses' notes
- ☐ Imaging/Radiology Reports
- ☐ Operative Report
- ☐ Lab/Test Results Only

Reason for request (optional)_____

- ✓ I understand that I may revoke or cancel this authorization at any time.
- ✓ I understand that any information/PHI released previous to this revocation or cancellation has been released in good faith and is now in the records of a healthcare entity or provider as previously authorized.
- ✓ I understand that PHI that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- ✓ I also understand that the Facility is not responsible for any misuse or disclosure made by a third party to whom I have authorized release of the PHI.
- ✓ I understand that I have the right to request or inspect or copy my PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- ✓ I understand that I can refuse to complete this authorization.
- ✓ I understand that I do not have to provide a reason for requesting release of my PHI.
- ✓ I understand that there may be nominal charges for copying and sending these records. This will be discussed at the time I sign or turn in this request.
- ✓ I understand that under HIPAA Privacy my access to PHI may be restricted if appropriate for my care and treatment.
- ✓ I understand that records/PHI from other healthcare entities or providers will not be released by this authorization. I will request that PHI from that entity or provider separately.

I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol abuse program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes); information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to state and federal laws and regulations. By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization as stated above. _____ **INITIALS**

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Description of Personal Representative's Authority/Relationship

REV. 4/06

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City, ST, Zip: _____

Dates and Type of information to disclose:

- ☐ 2 years prior from last date seen
- ☐ Dates Other: _____
- ☐ Specific Information Requested:

_____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care (e.g., VA Med Ctr)
- ☐ Referral
- ☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: **Coronado Surgery Center**

Address: **2779 W. Horizon Ridge Parkway, Suite 140**

City, State, Zip: **Henderson, NV 89052**

Fax: **702-589-9257** **Phone:** **702-589-9250**

- ☐ **Please mail records.**
- ☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative