

# FORM-MULTIPLE AUTHORIZATION

## AmSurg Center Non-System Policies

### FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service.

### ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to North Metro Surgery Center, my admitting physician, or other physicians who render service to me. The undersigned individual guarantee prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct.

### RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician, or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

### DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at North Metro Surgery Center may have an ownership interest in North Metro Surgery Center. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at North Metro Surgery Center.

### CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

### PATIENT RIGHTS/ADVANCE DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding North Metro Surgery Center policies pertaining to ADVANCE DIRECTIVES prior to the procedure. Information regarding Advance Directives, along with applicable state forms are available for me upon request.

- (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 .
- (Initial) I do not have Advance Directives, but have been informed and have been offered the applicable Minnesota forms.
- (Initial) I have received a copy of Notice of Privacy Practice and Patient Bill of Rights. Yes  Declined

The undersigned certifies that he/she has read and understands the foregoing and full accepts all terms specified above.

X

Signature of Patient or Responsible Party

X

Print Name

X

Relationship to Patient

X

Date Signed

02/02/15