SURGERY CENTER OF SOUTH CENTRAL KANSAS

FINANCIAL AGREEMENT

If you have insurance, we will help you receive maximum benefits by filing for you.
We accept MasterCard and Visa.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid to the Center who renders service to me. I understand and agree to be financially responsible for charges not paid for within a reasonable period of time by insurance or other third-party payor, and certify that the information given with regard to insurance coverage is correct.

RELEASE OF INFORMATION

I authorize the Center rendering service to release all or part of my medical records when required for the submission of any insurance claims for payment of services rendered by the Center. The Center, its agents, servants and employees who render services to me are hereby released from any and all liability of any nature that may arise from the release of such information.

DISCLOSURE AGREEMENT

I have been informed prior to this surgery / procedure that the physician who is rendering services may have an ownership interest in the above referenced facility. The facility physician owners are Dr. Strange, Dr. Wellemeyer, Dr. Rettig and Dr. Friesen. The physician has given me the option to be treated at another facility, which I have declined. I wish to be treated at the above referenced facility.

AUTHORIZATION TO LEAVE MESSAGES

In the event that I am not home or am unable to answer the phone, I give my permission for the caller to leave information pertaining to my treatment with a family member, caregiver, or on my answering machine. I acknowledge that someone other than myself could access any instructions left on my answering machine. I do not consider any of the above options a breach of confidentiality.

TREATMENT AUTHORIZATION

In the event that a health care worker is suspected to have been exposed to my blood or body fluids or in the event that my illness requires such care that health care worker exposure to my blood and body fluids is likely, I consent to have the above provider(s) determine by serological testing whether or not my blood contained contagious viruses. I understand the information obtained from such tests will only be exposed as necessary to adequately protect my own health and the health of my family, as well as the health care personnel who may become involved in my treatment.

PRIVACY PRACTICE

Attached is the **Notice of Privacy Practices** for our facility. The Health Insurance Portability and Accountability Act (HIPAA) mandates this notice. The law requires that we obtain your signature acknowledging that you have received our Notice of Privacy Practices. Your signature below does not indicate you have read or agreed with this notice, only that you have received it. If you have any questions, ask to speak with the Center Director or the HIPAA Privacy Officer. If not signed, reason why acknowledgment was not obtained:

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PATIENT RIGHTS / ADVANCE DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. Information regarding Advanced Directives along with official State documents have been offered to me upon request. ADVANCED DIRECTIVES will be honored within this facility. I have been offered a paper copy of this to take with me today.

CERTIFICATE

The undersigned certifies that he / she has read and understands the foregoing and fully accepts terms specified above. I hereby acknowledge receipt of the notice of Privacy Practices given to me.

X_____ _____ _____

Signature | Date | Signature of Guardian / Responsible Party

_____ _____

Staff Witness Seeking Acknowledgement | Date