Eastern Massachusetts Surgery Center

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 Eastern Massachusetts Surgery Center, my admitting physician, or other physicians who render service to me. The undersigned individual guarantees 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 the date of the procedure that the physicians who perform procedures/services at Eastern Massachusetts Surgery Center may have an ownership interest 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 the procedure/services performed at Eastern Massachusetts Surgery Center.

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

I hereby acknowledge that a copy of the Notice of Privacy Practices for Center has been made available to me. I have the right to obtain an addition paper copy upon request.

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 BROCHURE /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 Eastern Massachusetts Surgery Center policies pertaining to ADVANCE DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

- **Do you have an ADVANCE DIRECTIVE? Yes_____ No_____**
  - **If "yes" did you bring it with you? Yes_____ No_____**
  - ***If "no" you have the right to request one. Do you request one? [ ] yes [ ] no [ ] Given a copy**

PROCEDURE AND BILLING COMMUNICATION AUTHORIZATION

I hereby authorize the Center's agents and/or the physician(s) and their staff involved in my procedure to obtain the necessary consents. I allow communication of information regarding my procedure/results of my procedure/billing to/with:

- **My spouse/family member/other Name(s): _____ _____Initials**
- **Leave a message on my answering machine: Yes_____ No_____ _____Initials**

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

_____	_____	_____
Signature of Patient or Responsible Party	**Print Name**	**Date**

Relationship to Patient (if not the patient): [ ] Parent [ ] Guardian [ ] Other _____