Waverley Surgery Center
400 Forest Avenue
Palo Alto, CA 94301
650.324.0600

Waverley Surgery Center

WAVERLEY SURGERY CENTER
CONSENT FOR CONDITIONS OF ADMISSION AND RELEASE OF INFORMATION,

You may review or download documents at www.waverleysurgery.com. You may also request copies at admission.

Please initial each statement.

1. _______I acknowledge and understand my Patient Rights and Responsibilities.

2. _______ I have been informed of the Center's policies on advance directives or have been offered State advance directive forms.

3. _______ I understand that my physician may be an owner of the Center and that I have the right to choose another healthcare facility without repercussion.

4. _______ I hereby consent to the release and transfer of records if it becomes medically necessary to be transferred to hospital. I further consent to the release of the related discharge records to the Center upon discharge from that hospital.

5. _______ I hereby authorize direct payment to Center of any insurance benefits otherwise payable to me or on my behalf for the procedure(s) performed at the Center, at a rate not to exceed the Center's regular charges. It is understood by the undersigned that he/she is finally responsible for any charges not covered by this Assignment of Benefits consent. This Assignment of Benefits consent is valid for all insurance companies and programs, including Medicare.

6. _______ I authorize the Center to release medical information concerning the procedure(s) performed at the Center as may be requested by third party payors in order to process payment of my claim(s) in accordance with HIPAA regulations.

7. _______ I acknowledge that I am responsible for co-payments incurred on procedures that are cancelled yet deemed billable to the insurance carrier according to AMA (American Medical Association) guidelines. If a co-payment is collected and the procedure is cancelled and deemed non-billable according to AMA guidelines, the co-payment will be transferred to the rescheduled date of service or refunded.

8. _______ I have received a copy of the Financial Policies.

YOUR SIGNATURE BELOW IS REQUIRED UPON ADMISSION TO THE CENTER.

____

Patient (Please print) Date

____ ______________

Patient/Guardian/Surrogate Signature (indicate) Date

____

Witness

Waverley Surgery Center
400 Forest Avenue
Palo Alto, CA 94301
650.324.0600

FINANCIAL POLICIES AT WAVERLEY SURGERY CENTER

BILLING PRACTICES:
Waverley Surgery Center ("Center") will bill the responsible party's insurance company for facility charges. The Center will also collect any co-payments, co-insurance, and/or deductibles at the time of surgery. The responsible party will be billed for any remaining charges not covered by the insurance, including co-payments, co insurance and/or deductibles within 30 days. Additionally, the responsible party will be billed for facility charges in full should the insurance company deny coverage due to lack of referral, no pre-authorization, lack of proper reporting of the incident/accident, or lack of individual coverage, where applicable.

For Workers' Compensation claims, there will be no balance billing for any costs or fees associated with collections unless Waverley receives written notice from the employer that the claim was rejected for the injury for which the service is received.

PLEASE NOTE: It is the patient's responsibility to understand their individual insurance benefits.

PATIENT RESPONSIBILITY ESTIMATE:
Any fees collected at the time of service and any quotes regarding such fees are estimated based on the information available to the Center at the time of service. The Center relies on information provided by the responsible party regarding insurance coverage, information from the responsible party's insurance company, and procedure fees associated with the CPT codes scheduled/reserved and provided to the Center by the patient's surgeon. ***This estimate does not include the fees for the physician, anesthesiologist, laboratory, pathology, durable medical equipment and possibly implants. This quote is only an estimate.*** There may be additional charges, should the surgeon perform a procedure that is different from or in addition to what was scheduled.

COLLECTION ACTIVITY:
Any account balance that is not paid within 90 days from the date you were billed by the Center may be forwarded to an outside agency for collection follow-up. Any account balance that remains unpaid after this transfer may be eligible for reporting to a credit bureau. Should litigation be necessary to collect an outstanding balance owed, the responsible party agrees to pay all costs of collections including, but not limited to, collection fees, attorney fees, interest, and court costs.

PAYMENT ARRANGEMENTS:
Payment arrangements are available. Patients are encouraged to ask about this option if they are interested. Any payment arrangements should be arranged prior to services being provided.

If you have any questions or concerns, please contact the Business Office at (650) 324-0600.

Thank you for choosing Waverley Surgery Center.