FINANCIAL RESPONSIBILITY AND AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Estimated Portion due from the undersigned is due on or before the date of surgery, unless the undersigned has previously made alternate arrangements with our Business Office.

ESTIMATED PROCEDURE CHARGE/ALLOWABLE: $ _____

ESTIMATED PORTION DUE FROM PATIENT: $ _____

In consideration of the services to be rendered to the patient, the undersigned (as the patient, the patient's legal representative, parent, guardian, spouse, guarantor, or agent individually promises and agrees to pay the patient's account at the rates and terms stated in the Surgery Center's price list (known as the "Charge Master") effective on the date of service, which rates are hereby expressly incorporated by reference as the price terms of this Agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or the charge is listed as zero. In the event that the Surgery Center has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented to and services provided herein, the undersigned agrees to pay the reasonable attorney's fees and collection expenses, including, without limitation, collection agency expenses, incurred by the Surgery Center.

An estimate of the anticipated charges for services to be provided to the patient is available upon request from the Surgery Center. Estimates may vary significantly from the final charges based on a variety of factors, including, but not limited to, the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

In consideration of facility, medical and/or anesthesia services rendered to me or my dependants, I hereby assign and transfer any benefits due me under an insurance policy in so far as they are necessary to cover the expenses. If I maintain an insurance policy, then I, as the policy holder, do hereby authorize the payment of any benefits due me or my dependents under such policy in accordance with this assignment.

The insurance information that has been supplied to this facility is _____ and this center { ❑ is / ❑ is not } a participating provider of services with your insurance plan. Furthermore, the physician or other healthcare provider(s) who may provide you service today may not be participating providers with your insurance plan. **INITIAL:** _____

You will receive separate bills from the pathologist, radiologist, anesthesiologist, treating and consulting physicians who have provided services to you at the Surgery Center.

I authorize the release of medical, protected health and insurance information to the admitting physician, emergency physician, anesthesiologist, radiologist, pathologist, consulting physician, and institutions performing special tests or providing special equipment or supplies. I further request payment of Medicare or other insurance benefits be made to these physicians for professional services rendered while I, or one of my dependents was a patient at the Surgery Center. **INITIAL:** _____

The Surgery Center may use or disclose information about you to bill or receive payment for medical treatment or services and/or supplies provided to you to which you consent to by your signature below. These disclosures include, but are not limited to, releasing information:

1) to your health plan to obtain prior approval or to determine whether your plan will cover the treatment or services; and
2) to individuals or entities involved in collecting amounts owed to us.

I have received this Surgery Center's Notice of Privacy Practices. I understand that if I have any questions or complaints I may contact the Surgery Center's Facility Privacy Official. **INITIAL:** _____

I have been provided verbal and written notice of the Patient Rights and Responsibilities in advance of my procedure in a language and manner that I understand. **INITIAL:** _____

I hereby consent to and authorize all diagnostic and therapeutic treatment performed at the Surgery Center considered necessary or advisable in the judgement of the attending physician. **INITIAL:** _____

Signature _____ _____ _____ _____

PATIENT (OR PARENT IF MINOR) | DATE | WITNESS | TIME

If the patient is a minor or unable to sign, complete the following:

❑ Patient is a minor ❑ Patient is unable to sign because _____

_____

PATIENT | PARENT | LEGALLY DESIGNATED REPRESENTATIVE

Relationship to Patient if Patient does not sign _____

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

_____ _____

NAME | RELATIONSHIP | NAME | RELATIONSHIP

_____ _____

NAME | RELATIONSHIP | NAME | RELATIONSHIP

_____

SIGNATURE OF PATIENT (OR PARENT IF MINOR)

PATIENT IDENTIFICATION:

St David's | North Austin Surgery Center

12201 Renfert Way, Suite 120 • Austin, Texas 78758

NAS-003 (08/12) Tel. 512. 832.9088 Fax. 512.833.6137