CONSENT FOR ADMISSION AND TREATMENT

Consent to Medical Care: I request admission to FOREST LANDING SURGICAL CENTER ("**FLSC**") and authorize the facility, staff and physicians to provide care. I request and consent to medical care and diagnostic procedures that my attending physician(s), or his/her designees, determine are necessary. I acknowledge that the medical care I received while in **FLSC** is under the direction of my attending physician(s) and that **FLSC** is not responsible for acts of omission of my attending physician(s). I authorize **FLSC** to retain or dispose of any specimen or tissue taken from the above named patient.

Teaching Programs: I understand that **FLSC** is a facility that promotes educations opportunities, and therefore, I understand that I may be seen and examined by supervised participants as a part of the educational program. I agree to participate in these programs, but reserve the right to limit my participation at anytime.

Disclosure of Information: The undersigned agrees that all records concerning this patient's hospitalization shall remain the property of the facility. The undersigned understands that medical records and billing information generated or maintained by the facility are accessible to facility personnel and medical staff. Facility personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations to any other physician, healthcare personnel or provider that is or maybe involved in the continuum of care for this admission. The facility is authorized to disclose all or part of the patient's medical record to any insurance company, third party payor, workers compensation carrier, self-insured employer group or other entity (or their authorized representative) which are necessary for payment of patient's account. Law requires that the facility advise the undersigned that **THE INFORMATION RELEASED MAY INDICATE THE PRESENCE OF A COMMUNICABLE ORVENERAL DISEASE WHICH MAY INCLUDE, BUT NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS,GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS AQUIRED IMMUNEDEFICIENCY SYNDROME (AIDS).**The facility is authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing. By signing this form, you are authorizing such disclosures.

Special Consent for HIV Testing: The undersigned specifically consents to the testing of the patient's blood for human immunodeficiency virus (also known as AIDS) and/or Hepatitis if determined by patient's attending physician to be necessary(I) for determining the appropriate treatment and/or treatment procedures for the patient or (II) for the protection of the attending physician and/or employee or agent of the facility or the attending physician exposed to the bodily fluids of the patient in a manner which could transmit such disease. The undersigned has been informed about the nature of the blood test, its expected benefit, and has been given the opportunity to ask questions about the blood test.

☐ Do ☐ Do Not I (we) authorize **FLSC** and/or my physician to photograph/video or permit other persons to photograph/video for such purposes as may be deemed necessary.

☐ Do ☐ Do Not I (we) consent to the presence of students, residents or fellows, and vendors in the operating room to observe the procedure. I am aware that only the physician may grant this permission on my consent.

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 other ☐ **Yes** ☐ **No** ☐ **Limit disclosure to persons listed below:**

Names: _____ **Name:** _____

I (WE) THE UNDERSIGNED CERTIFY THAT I (WE) HAVE READ AND FULLY UNDERSTAND THIS "CONSENT FOR ADMISSION AND TREATMENT".

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

FOREST LANDING SURGICAL CENTER ("FLSC")

The Physicians and Allied Health Professional ("AHPs") practicing at **FLSC** are licensed and/or credentialed to practice in this facility. The physicians and AHPs provide medical services at **FLSC**, but they are not agents or employees of **FLSC**.

Financial Agreement: For services hereto performed or to be performed for the Patient by **FLSC** (whether one or more), below signed (severally if more than one), whether as patient, agent or guarantor, agrees and promises to pay the charges for the care so provided to the Patient by **FLSC** in accordance with **FLSC** then current standard rates and all costs incurred in collecting same, together with attorney's fees, which **FLSC** deems necessary and reasonably required to enforce the rights of **FLSC**.

Assignment of Insurance Benefits to FLSC: As or on behalf of the Insured under the insurance specified on the registration documents of the Patient, and otherwise payable thereto (the present and future rights thereto and monies due or to become due there from termed "Contract Rights", the below signed irrevocably assigns and transfers to **FLSC** or its assignee. To effect such payment, **FLSC** irrevocably constituted and appointed lawful attorney in fact with substitution power, to sue or otherwise collect and settle any claim under the Contract Rights as insured without further notice or approval in Insured and to endorse in the name of the Insured any check or other instrument for the payment of monies hereunder. Further, I understand that **ANESTHESIOLOGY, PHYSICIANS SERVICES, PATHOLOGY, RADIOLOGY**, and some **LABORATORY SERVICES** will bill me separately and assign my insurance benefits to them if their services are rendered during my treatment. I also authorize them to release my medical information needed by my insurance carrier to process the claim.

If Insured received monies directly from the Insurer(s), same shall be held in trust and immediately transfer to **FLSC** for amounts due. This assignment is irrevocable with interest until full and complete payment of all monies due to the Facility and its affiliates from this event of admission or otherwise. Money received by **FLSC** from Insurer(s) or other third party sources, less the expense in procuring same, shall be deducted from the principal amount due for services rendered to the Patient. If charges not covered by insurance cannot be paid in full when due, below signed agrees upon request to sign a promissory note bearing interest at the maximum legal rate to pay all debts not paid, if credit is approved.

Insurance Pre-certification: I understand that pre-certification for my insurance is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.

Medicare Assignment, Patient's Certification, Authorization to Release Information and Payment Request:
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or any related Medicare claims. I request that payment of authorized benefits be made on my behalf.

Acknowledgement of Notice of Privacy Practices: A description of how your medical information will be used and disclosed is summarized on the Patient Privacy Notice. A complete copy of the Facility's Notice of Privacy Practice is included in your admissions packet and post in the Facility. By signing below you acknowledge that you have received a copy of the Facility's Notice of Privacy Practice.

Advance Directives: FLSC does not follow any predetermined Advance Directives. If you have any questions please talk to your physician or anesthesiologist.

Patients' Rights: I acknowledge receipt of information explaining my rights as a patient and, on request. I received a copy of the State notice and this facility's policy statement regarding Patient's Right of Self-Determination.

I have been informed that my physician may be a partner in ownership of **FLSC**. I have the right to review a list of partners.
