AMBULATORY SURGERY CENTER

# Financial Information

You may receive bills from several different providers for the care rendered to you today; The physician performing the procedure, the Ambulatory Surgery Center (ASC), and a laboratory if specimens are obtained during your procedure.

**Financial Agreement**

If you have insurance, we will help you receive maximum benefits by filing for you; however, we will expect payment of co-pays, co-insurance, and deductibles at the time of service. Does your insurance require you to use certain network physicians/facilities? If so, we may or may not be in your network! It is your responsibility to know this information. The undersigned individual guarantees prompt payment of all charges if the insurance carrier rejects the claim of any charges related to this account. If charges remain, unpaid, it may become necessary to turn the account over to a collection agency.

A $25.00 no-show fee will be accessed if you fail to cancel an appointment prior to your appointment date/time.

**Assignment of Insurance Benefits**

Medicare/Medicaid/Other Insurance

I hereby assign benefits to be paid, on my behalf, to the Physician and ASC that renders service to me. I understand and agree to be financially responsible for charges not paid within a reasonable time by insurance or other third party payer. I certify the information given with regard to insurance coverage is correct.

**Release of Information**

I authorize the Physician/ASC to release all or part of my medical records where required for the submission of any insurance claims for payment of the Centers of Medicare and Medicaid Services and their agents, my insurance company(s), or to my employer (if this is a worker's compensation claim).

I also authorize reports of my evaluation, treatments, and any follow up evaluations to be sent to or discussed with my referring Doctor, the Doctor requesting the consultation, my family Physician(s), as well as any other healthcare providers, hospitals and outpatient facilities that I have or will identify to you.

I permit a copy/fax of this form to serve as an original signature of authorization.

**Disclosure of Ownership**

I have been advised of the following:

A physician performing the procedure may have an ownership in this facility.

Owner of Pain Treatment Center is David L. McKellar

A schedule of typical fees for services provided by this facility is available upon my request. These procedures are performed at hospitals and other outpatient facilities in this community. I have the right to choose where to receive services, including a facility where my physician does or does not have an ownership interest. I have chosen to be treated at this facility.

**Policy of Advanced directive**

It is the policy of Pain Treatment Center to make available to our patients a description of the State health and safety law and official State advance directive forms, if requested.

It is our desire to honor advance directives, however, if an untoward event happens to a patient while he/she is at the facility, it is our policy to:

**Stabilize and transport them to the hospital with a copy of their advance directive (if it has been made available to us).**

If a patient has chosen not to be resuscitated, in the event of an emergency, it is their right to schedule their procedure/treatment in a hospital setting with another provider, rather than in this facility.

**Certification**

I have been provided verbal and written notice of the Patient Rights in advance.

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Patient Signature Date