SURGERY CENTER AT HAMILTON

Conditions of Admission
Acknowledgement, Consent and Financial Responsibility Agreement

In this document, Surgery Center at Hamilton, is referred to as "Facility" and the person signing this document is referred to as "you". If you are the patient, the term "you" in this document refers to you, the patient. You acknowledge and agree to all the following conditions for outpatient treatment at the Facility.

1. **General Medical Consent**
   You consent to the procedures which may be performed on an outpatient basis, which may include but are not limited to x-ray examinations or laboratory procedures or other services rendered under the general and special instructions of your attending physician or surgeon.

2. **Acknowledgement of Participation of Physician Resident and Health Care Students**
   The Facility may participate in various teaching programs through which physician residents, medical students, student nurses, and/or students in other health care fields receive on-site training as part of their education. From time to time, these persons may participate in your care as part of their education program, unless you indicate that you do not agree to such participation. Such persons are under the supervision of licensed professionals.

3. **Legal Relationship Between the Facility and Physician**
   All physicians furnishing services to you, including, but not limited to, radiologist, pathologists, emergency physician's ad anesthesiologists are independent contractors and are not employees, representatives or agents of the Facility. You are under the care and the supervision of your attending physician and it is the responsibility of the Facility and its nursing staff to carry out the instructions of that physician and any other consulting physician. It is the responsibility of our physician(s) to obtain your informed consent, when required, to medical or surgical outpatient treatment, special diagnostic or therapeutic procedures or outpatient services rendered to you under the general and/or special instructions of your physician.

4. **Release of Information**
   Except in those instances where the hospital is permitted or required by state or federal law to release information about you, the Facility will obtain your consent and your written authorization to release information about services rendered to you as an outpatient.
   The law provides that your consent must be obtained so that the Facility may use or disclose your medical information to provide medical treatment to you, and to the extent necessary for health care operations and to determine liability for payment or to obtain reimbursement. By signing below, you acknowledge your consent, or your legal representative's consent on your behalf. Disclosure may be made be performed by the Facility or its authorized agents, who will also have a binding obligation to maintain the confidentiality of your patient information. Special permission may be required to release this information, or other information, or other limitations on release may apply, if you are treated for alcohol, drug abuse, or Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), or if you receive certain mental health related services.

5. **Admission to Hospital**
   In the event of an unforeseen circumstance that cannot be accommodated on an outpatient basis, it may be necessary to admit you to a hospital for treatment.

6. Financial Agreement

You, the patient, or a person who is legally responsible for your debts (such as you spouse, your parent, or guardian if you are a minor patient, or the conservator of your estate), acknowledge and agree that in consideration of the services to be rendered, you are obligated to pay the Facility in accordance with the regular rates and terms, except as otherwise provided by law. Should your account be referred to any attorney or collection agency for collection, you agree to pay the facility's reasonable attorney's fees and costs and collection expenses. All delinquent accounts shall bear interest at the legal rate.If you are not legally responsible for paying your debts, then the person legally responsible for such debts must assume financial responsibility for the outpatient services provided to you by the signing Financial Responsibility Agreement below.

If there is an indication that you may have an emergency condition (as defined by law), the Facility will provide with an appropriate medical screening examination and, if necessary, stabilizing treatment regardless of your ability to pay or payment source. Thereafter, if no one assumes financial responsibility for services provided to you, either under this section of the Financial Responsibility Agreement, and that if it as been determined that you do have an emergency medical condition, then the Facility may decline to treat you.

7. Assignment of Insurance Benefits

Whether you sign for yourself as the patient, or whether your legal representative of your agent signs on your behalf, you or your legal representative or agent assign and authorize direct payment to the Facility and to the Facility-based physicians such as radiologists, pathologists, emergency physicians, or anesthesiologists as appropriate, of any insurance benefits otherwise payable to you or on your behalf for outpatient services provided here at a rate not to exceed the Facility's regular charges. You further acknowledge and agree that when an insurance company or other healthcare pays the Facility, pursuant to this assignment and authorization, any and all obligations that the insurance company or other payor had under a policy are discharged to the extent of payment. You, or a person financially responsible for the outpatient services provided to you, understand and agree that, except as otherwise provided by law, you are obligated to pay any charges for the outpatient services that are not paid as a result of this assignment and/or proper authorization.

8. Health Care Service Plans

This Facility maintains a list of health care service plans with which it contracts. A list of such plans is available upon request from the Business Office. The Facility has no contract express or implied, with any plan that does not appear on the list. You, or a person financially responsible for the outpatient services provided to you, acknowledge and agree that, except as otherwise provided by law, you are obligated to pay the Facility's regular rates for all services rendered to you by the Facility if you belong to a plan that does not appear on the above-named list. You also acknowledge and agree that, except as otherwise provided by law, you are individually liable to pay for any treatment, procedure or service ordered by your physician(s) if your health services plan appears on the above-mentioned list, but the plan refused to pay for the treatment, procedure, or service for any reason, including but not limited to, a plan determination that the treatment procedure or service was not covered by the plan, was not authorized by the plan or was not medically necessary.

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Acknowledgement, Consent and Financial Responsibility Agreement by Patient or Patient's Legal Representative or Authorized Agent.

I, _____(Name of Patient) certify that I have read, understand, and agree to the foregoing (General Medical Consent, Acknowledgement or Participation of Physician Resident and Health Care Students, Legal Relationship Between the Physician and the Facility, Release of Information, Admission to Hospital, Financial Agreement, Assignment of Insurance Benefits and Healthcare Service Plans) and have received a copy of it and are either the patient, the patient's legal representative, or the person authorized by the patient' agent to execute this document and to accept its term.

Signature **X**_____ Date: _____

I am the ☐Patient

If: ☐Guardian ☐Legal Rep Printed Name:_____

Surgery Center at Hamilton Witness: _____ Date:_____

Financial Responsibility Agreement by Person Other that the Patient or the Patient's Legal Representative:

I agree to accept financial responsibility for outpatient services rendered to the patient. In particular, I accept the term of the Financial Agreement, Assignment of Insurance Benefits, Health Care Services plans and Third Liability provisions stated above.

_____ **X** _____ _____

Printed Name (Patient or Patient's Legal Representative or Authorized Agent) | Signature (Patient or Patient's Legal Representative or Authorized Agent) | Date

_____ _____

If signed by any one other that the patient, please indicate relationship | Time

_____

Surgery Center at Hamilton Witness Signature