

## SURGERY CENTER ADMISSION

**LEGAL RELATIONSHIP BETWEEN SURGERY CENTER AND PHYSICIANS:** I understand that all physicians furnishing services to the patient, including the patient's physician, and any specialist such as an anesthesiologist, radiologist, or pathologist are independent contractors with the patient and are not employees or agents of the surgery center. The patient is under the care and supervision of his/her physician and it is the responsibility of the surgery center and its staff to carry out instructions of the physician. It is the responsibility of the patient's physician to obtain the patient's informed consent, when required for medical or surgical treatment or procedures. Any questions concerning the nature or results of any examination or treatment should be directed to the patient's physician and not to the surgery center employees.

**OTHER PROFESSIONAL SERVICES:** I understand that my physician may have a professional radiology service review radiological images. My physician may also send specimens to a professional pathology laboratory for a pathological diagnosis. Radiology and pathology services are billed separately by those individual physicians and laboratories. I understand that my anesthesia services are billed separately by those individual anesthesiologists or certified registered nurse anesthetists.

**PERSONAL VALUABLES:** It is agreed and understood that the surgery center shall not be responsible for any personal property brought by the patient to the surgery center, including but not limited to money, jewelry, documents, or any other articles.

**OWNERSHIP OF THE SURGERY CENTER:** I have been notified prior to my date of surgery and understand that my physician may be an owner of this surgery center. I understand that I am free to choose another facility in which to receive the services that have been ordered by my physician.

**ADVANCE DIRECTIVE/LIVING WILL:** I have been offered information regarding an advance directive/living will. I understand that if I have an advance directive/living will, the surgery center will *not honor* an Advance directive/living will, as life saving measures are made in the event of an emergency. I understand; however, that the facility will transfer me to the closest hospital which will make decisions about following any advance directive/living will.

**PATIENTS' RIGHTS AND RESPONSIBILITIES:** I acknowledge that I have been given a copy of my patients' rights and responsibilities prior to my date of surgery. I know to whom I can express suggestions or complaints.

**PATIENT PRIVACY NOTICE:** I acknowledge that I have been given a copy of the surgery center's privacy notice prior to my date of surgery.

**FINANCIAL AGREEMENT:** I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the surgery center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the Center's charges (including but not limited to insurance companies, health care service plans, or worker's compensation carriers). Whether signing as the patient or his/her agent, I agree that in consideration of the services rendered, I shall be individually responsible to pay the Center for all services at the Center's regular rates and terms should my insurance company deny payment. I shall also be responsible for any deductibles or co-payments owed at the time of services. I hereby certify that the information given by me in applying for payment under Titles XVIII and XIX of said policies and programs but not to exceed the Center's regular charges for similar services.

**I HEREBY ACKNOWLEDGE THE ABOVE STATEMENTS.**

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
In the event the patient is a minor, unconscious, or is otherwise not competent to acknowledge an understanding due to physical or mental condition, complete the following.

\_\_\_\_\_  
Patient's Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient