Patient Label

TWO RIVERS SURGERY CENTER FACILITY CONSENT FORM

Patient Name_____ Date: _____
(print)

CONSENT FOR TREATMENT

I, the above named and undersigned patient, give my consent for care at and by the medical, nursing allied professional staff at Two Rivers Surgery Center, which may include routine diagnostics procedures and such medical treatment as my doctor or his designees may find are needed. I acknowledge that no promises or guarantee have been made to me about the results of any examinations, treatments or procedures I may receive at the center.

RELEASE OF MEDICAL RECORDS

I authorize the center to release all or any part of my medical records to (a) hospitals or medical services companies, insurance companies, workers compensation carriers, welfare funds or other organizations or agencies that may be concerned with the payment of costs related to my treatment and (b) any other organization or agency to which the center is permitted to release such information under applicable laws. In the event I am transferred or admitted to a hospital post-operatively, I authorize the center to obtain a copy of the hospital discharge summary.

FINANCIAL ARRANGEMENTS

I authorize and direct my insurance or payer to pay directly to Two Rivers Surgery Center any or all benefits, up to the amount of my bill, accruing to me in connection with my treatment. I agree that, in consideration of the services that were provided to me, I individually obligate myself to pay the amount promptly in accordance with the regular rates and terms of the facility. I understand, therefore that to the extent permitted under applicable laws and contractual arrangements, I am financially responsible to the center for any amounts not covered by insurance. Furthermore, I understand that my insurer or payer may require certain healthcare services to be authorized before they are furnished to me. I individually obligate myself to pay the account of the center with respect to the services that I choose to receive not withshtanding that my health insurer or payer has refused to give preauthorization for all or any portion of my services.

PRE-CERTIFICATION

Your insurance company will be called to pre-certify your procedure. Please make sure that we have the correct insurance information. It is important to notify us if you have different plans for the surgeon and hospital services.

☐ (Pt to initial) **I understand that I am using my Out-of-Network benefits. Two Rivers Surgery Center is not contracted with my insurance company to provide services. I understand that the reimbursement may be sent to me instead of the center and that upon receipt of the insurance payment I am to forward the check and the Explanation of Benefits (EOB) to the center. An administrative fee of $100 will be incurred if the insurance check is not forwarded to the center within 7 days. I understand that my insurance plan may still hold me responsible for a deductible and/or coinsurance. I also give permission for any billing agency contracted with Two Rivers Surgery Center to contact my insurance company on my behalf and to handle appeals.**

FACILITY and ANESTHESIA CHARGES

When your procedure is performed at Two Rivers Surgery Center, there will be a facility fee. This is a charge for the use of the surgical suite for your procedure, you will also be charged a fee for Anesthesia services, this is a separate fee payable to the Anesthesiologist directly. The fees vary according to how long the procedure takes and the type of procedure. Patient responsibility is dependent upon individual insurance plans.

IF YOU HAVE QUESTIONS ABOUT THE ABOVE INFORMATION, PLEASE SPEAK TO THE BILLING MANAGER.

COLLECTION EXPENSES: (Medicare excluded) Should my account with the surgery center be referred to an attorney or outside agency for collection, I will pay all reasonable collection expenses (including attorney's fees) associated with the collection effort. I acknowledge that all delinquent accounts will bear interest at the legal rate.

My signature below indicates that I have read and understand the above.

_____ _____
Patient's signature or their representative Date

_____ _____
Witness's signature Date