

TWO
RIVERS
SURGERY
CENTER LLC

FINANCIAL DISCLOSURE STATEMENT

*The Following Physician Has a
Financial Investment in*
Two Rivers Surgery Center, LLC

John M. Taylor, MD

Patient Acknowledgement of Information Received

Dear Prospective Patient:

We are delighted that you have chosen Two Rivers Surgery Center, LLC for your elective surgery. The State of New Jersey requires that you receive documentation of the following items prior to your surgery.

- *Patient's Rights and Responsibilities
- *HIPAA Notice of Privacy Practices
- *Advance Directives Information
- *Physician Ownership Disclosure

Please sign below

I certify that I have received verbal information and written documentation of the above items, in advance of the date of my scheduled procedure.

Furthermore, I understand that this information is being provided for my benefit and that should I have any questions regarding its content, I should contact Two Rivers Surgery Center for clarification.

Patient's Signature

Date

Time

TRSC PRIVACY POLICY

Two Rivers Surgery Center, LLC respects the confidentiality of your health information and we will protect your information in a responsible and professional manner.

We are required by federal and state laws to make you aware of the following issues that specifically pertain to your treatment, procedures or sessions.

1. Your surname will be included on a weekly or daily appointment schedule that will be located at the front/receptionists desk
2. Your medical record will be physically placed on the front/receptionist desk with other patient's charts. Your medical record will be physically placed on other staff members desks as necessary for coordination of care.
3. Your medical record will be available to all personnel connected with TWO RIVERS SURGERY CENTER, LLC as well as your referring physician/practitioner.
4. Your medical record will not be available to anyone not directly connected to your care.
5. Patient progress, consultative or diagnostic reports will be issued by fax or mail to other members of your healthcare team.
6. Your medical or billing chart may be used to submit insurance claims for payment to obtain insurance pre-certifications/authorizations, for appeals and collections, in cases of medical review, court orders or audits.
7. Sharing of information to any other patient designated agents by fax, email, mail or by telephone must be specifically authorized by you.

Patient's/Authorized Representative's Signature

Date

Printed Name

Two Rivers Surgery Center's Financial Policy

We are committed to providing you with the best care possible. If you have medical insurance, we are anxious and pleased to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Insurances:

If we participate with your insurance company, all services performed in our surgical center will be submitted to them, unless we have received prior notification of non-covered services. All co-pays, coinsurances and deductibles are the patient's responsibility and will be billed to you by our billing company.

If we do not participate with your insurance company, we will bill your insurance carrier, but we will not accept payment from them as payment in full for the services performed. All insurance carriers have a schedule of fees from which they will pay; (this is usually a discounted percentage of Medicare fees) however, Two Rivers Surgery Center's fees may be more than what the insurance company shows on their schedule. Therefore, any balance not covered by the insurance company becomes the responsibility of the patient. Payments for procedures are due at the time of service. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement. All deductibles are due 2 weeks prior your surgery.

For elective procedures not covered by insurance, full payment is due 2 weeks prior to your surgery. We accept cash, checks, and most credit cards. We also have financing options available; please inquire with our billing manager or your patient coordinator.

Signature _____

Date _____