# Daytime Outpatient Surgical Center
# Conditions of Admissions

**Consent for treatment:** The patient or his/her representative acknowledge the patient's need for medical care because he/she suffers from a condition requiring diagnosis and medical and/or surgical treatment. The patient request and voluntary consents to receive, under the general and special instruction of the attending physician(s), the usual Daytime Outpatient Surgical Center services. This includes but not limited to any diagnostic laboratory and radiological examinations, medical and/or surgical treatment, including anesthesia.

The undersigned recognizes that all physicians furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like are not agents, servants, or employees of the Daytime Outpatient Surgical Center, but are the agents, servants or employees of the patients.

**Personal valuables**: It is understood and agreed upon that no valuables will be stored by the Daytime Outpatient Surgical Center and the patient will not bring to the center. It is understood and agreed that the Daytime Outpatient Surgical shall not be liable for the loss or damage to any personal property, money, jewelry, glasses, dentures, documents, furs, fur coats, and for garments or other articles of unusual value and small compass.

**Release of information:** The Daytime Outpatient Surgical Center may disclose all or any part of the patient's medical records to any person, corporation or governmental agency which is or may become liable under contract to the Daytime Outpatient Surgical Center, the patient or responsible party for all or part of the Daytime Surgical Center charges. Such disclosure may include but not limited to Daytime Surgical Center service companies, insurance companies, workman compensation carriers, welfare funds, and the patient's or responsible parties employer or attorney.

**Release of Social Security Number**: The undersigned authorizes the release of their social security number to the manufacturer of medical devices that you receive so that it might be used to locate you in regards to the medical device, if necessary.

**Authorization for testing of communicable diseases**: I hereby authorize and consent to my blood being tested for communicable diseases including but not limited to HIV virus which is probable cause of Acquired Immune Deficiency Syndrome (AIDS) if ordered by my physician of if any person is exposed to my blood or other body fluids at Daytime Outpatient Surgical Center.

## Agreement of Financial Responsibility

**Assignments of Benefits:** In consideration of services rendered or to be rendered, I hereby irrevocably assign and transfer to the Daytime Outpatient Surgical Center all right, title, and interest in all benefits, payable for services/ supplies rendered, and in all causes of action against any party of entity that may be responsible for payment of benefits. I fully understand that by assigning benefits that the same shall not impose any contractual obligation or otherwise upon the Daytime Outpatient Surgical Center. I agree to fulfill all policy provisions/conditions required for payment of benefits by any insurance company or plan. I understand that regardless of my assigned benefits, I am fully responsible for the total charges and that payment is due upon request. I agree that if any payments result in credit balance, the same shall be applied to any outstanding accounts due to the Daytime Outpatient Surgical Center.

**Patient's Certification, authorization to release information and payment request**: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to they physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

**Financial agreement**: The undersigned agrees whether he/she as an agent or as a patient that in consideration of the services rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Daytime Outpatient Surgical Center in accordance with the regular rates and terms of the Daytime Outpatient Surgical Center. Should the account be referred for collection, the undersigned shall pay reasonable attorney's fees and collection expense. Furthermore, it is agreed that following the Daytime Outpatient Surgical Center's receipt of any such insurance payments, the patient or responsible party agrees to pay any unpaid balance when billed. Any dispute about whether the insurance completely discharged any and all obligations with the amount paid shall delay payment of the remaining balance or be construed to absolve or relieve the patient of this responsibility.

**Third party fees**: The undersigned understands that he/ she will be billed separately and agrees to pay for the following services, including but not limited to: Physician's fees, Anesthesiologist and CRNA related to anesthesia, Pathology, Laboratory, EKG, Durable Medical Equipment and Radiology Fees.

**Ownership:** The physicians at Daytime Outpatient Surgery Center may have ownership in the Center to further their commitment to the quality of care their patients receive. If this is a concern to you the center's Administrator and / or your physician will be happy to answer any questions.

**Complaints:** If you have a complaint regarding Daytime Outpatient Surgery Center please contact the center's administrator or you may contact the at 1(888)973-0022 or in writing to Texas Department of State Health Services, Manager, Health facility Compliance Group, P.O. Box 149347, Austin, TX 78714-9347.

**I have read and understand the information above and received a copy for my records:**

| | |
|---|---|
| _____ | _____ |
| Signature of patient or responsible party | Relationship to patient |
| _____ | _____ |
| Witness | Date |

Original – chart / Copy – patient